WORLD HEALTH ORGANIZATION

THIRTY-EIGHTH WORLD HEALTH ASSEMBLY

GENEVA, 6-20 MAY 1985

SUMMARY RECORDS OF COMMITTEES

GENEVA
1985
The following abbreviations are used in WHO documentation:

ACABQ - Advisory Committee on Administrative and Budgetary Questions
ACC - Administrative Committee on Coordination
ACMR - Advisory Committee on Medical Research
AGFUND - Arab Gulf Programme for United Nations Development Organizations
ASEAN - Association of South-East Asian Nations
CIDA - Canadian International Development Agency
CIOMS - Council for International Organizations of Medical Sciences
DANIDA - Danish International Development Agency
ECA - Economic Commission for Africa
ECE - Economic Commission for Europe
ECLAC - Economic Commission for Latin America and the Caribbean
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
UNSCEAR - 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
WHO - World Meteorological Organization

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

The Thirty-eighth World Health Assembly was held at the Palais des Nations, Geneva, from 6 to 20 May 1985, in accordance with the decision of the Executive Board at its seventy-fourth session. Its proceedings are published in three volumes, containing, in addition to other relevant material:

- Resolutions and decisions,¹ and list of participants - document WHA38/1985/REC/1
- Verbatim records of plenary meetings, and committee reports - document WHA38/1985/REC/2
- Summary records of committees - document WHA38/1985/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 1984. 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).
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President:
Dr. S. SURJANINGRAT (Indonesia)

Vice-Presidents:
Mr. D. S. KATOPOLA (Malawi)
Dr. W. CHINCHÓN (Chile)
Dr. Barbro WESTERHOLM (Sweden)
Dr. Aleya H. AYOUB (Egypt)
Dr. E. NAKAMURA (Japan)

Secretary:
Dr. H. MAHLER, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Austria, Botswana, Czechoslovakia, Ivory Coast, Mexico, Norway, Oman, Papua New Guinea, Sri Lanka, Trinidad and Tobago, Tunisia, Zaire.

Chairman: Mr. N. HADJ ALI (Tunisia)
Vice-Chairman: Dr. Q. REILLY (Papua New Guinea)
Rapporteur: Dr. E. KUBESCH (Austria)
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: Angola, Argentina, Bahrain, Barbados, Brazil, China, Egypt, Finland, France, Gambia, Guinea, Jordan, Maldives, Nigeria, Pakistan, Poland, Solomon Islands, Suriname, Thailand, Togo, United Nations of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America.

Chairman: Dr. A. NONDASUTA (Thailand)
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 Chairman of the main committees, together with delegates of the following Member States: Burma, Cameroon, China, Cuba, Ethiopia, France, Iraq, Jamaica, Jordan, Morocco, Nigeria, Senegal, Sudan, United Nations of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, United States of America.

Chairman: Dr. S. SURJANINGRAT (Indonesia), 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. D. G. MAKUTO (Zimbabwe)
Vice-Chairmen: Dr. J. VAN LONDEN (Netherlands) and Dr. A. AL-SAIF (Kuwait)
Rapporteur: Mr. J. F. RUBIO (Peru)
Secretary: Dr. D. K. RAY, Scientist, Health Manpower Planning

Committee B

Chairman: Mr. R. ROCHON (Canada)
Vice-Chairmen: Dr. B. P. KEAN (Australia) and Dr. M. M. PAL (Pakistan)
Rapporteur: Dr. Zsuzsanna JAKAB (Hungary)
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. [deleted]
10. Review and approval of the reports of the Executive Board on its seventy-fourth and seventy-fifth sessions
11. Review of the report of the Director-General on the work of WHO in 1984
12. Assignment of Israel to the European Region
13. Election of Members entitled to designate a person to serve on the Executive Board
14. Presentation of the Léon Bernard Foundation Medal and Prize
15. Presentation of the Dr A. T. Shousha Foundation Medal and Prize
16. Presentation of the Jacques Parisot Foundation Medal
17. Presentation of the Child Health Foundation Medal and Prize
18. Presentation of the Sasakawa Health Prize
19. Approval of reports of main committees
20. Closure of the Thirty-eighth World Health Assembly

COMMITTEE A

21. Election of Vice-Chairmen and Rapporteur
   22.1 General policy matters
   22.2 Programme policy matters
   22.3 Financial policy matters

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1 The agenda was adopted, as amended, at the third plenary meeting.
THIRTY-EIGHTH WORLD HEALTH ASSEMBLY

COMMITTEE B

23. Election of Vice-Chairmen and Rapporteur

24. Review of the financial position of the Organization
   24.1 Interim financial report on the accounts of WHO for 1984 and comments thereon of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Health Assembly
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   24.3 Members in arrears in the payment of their contributions to an extent which may invoke Article 7 of the Constitution
   24.4 Report on casual income, budgetary exchange rates and other adjustments to the proposed programme budget for 1986-1987

25. [deleted]

26. Scale of assessments
   26.1 Assessment of new Members and Associate Members
   26.2 Scale of assessments for the financial period 1986-1987

27. Working Capital Fund
   27.1 [deleted]
   27.2 [deleted]
   27.3 Review of the Working Capital Fund

28. Real Estate Fund

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

30. Recruitment of international staff in WHO: biennial report

31. Number of members of the Executive Board .

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

33. Collaboration within the United Nations system
   33.1 General matters
   33.2 Women, health and development
   33.3 Health assistance to refugees and displaced persons in Cyprus
   33.4 Health and medical assistance to Lebanon
   33.5 Liberation struggle in southern Africa: assistance to the front-line States, Lesotho and Swaziland
   33.6 Emergency health and medical assistance to drought-stricken and famine-affected countries in Africa

34. United Nations Joint Staff Pension Fund
   34.1 Annual report of the United Nations Joint Staff Pension Board for 1983
   34.2 Appointment of representatives to the WHO Staff Pension Committee

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GENERAL COMMITTEE

FIRST MEETING

Monday, 6 May 1985, at 17h00

Chairman: Dr S. SURJANINGRAT (Indonesia),
President of the Health Assembly

1. ADOPTION OF THE AGENDA AND ALLOCATION OF ITEMS TO THE MAIN COMMITTEES (Document A38/1)

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), so that it might be able to transmit that agenda (prepared by the Executive Board and issued as document A38/1) with its recommendations to the Assembly in plenary session.

He then announced that certain items included in the provisional agenda for consideration "if any" should be deleted. They were item 9 (Admission of new Members and Associate Members), item 25 (Supplementary budget for 1984-1985) and, under item 27 (Working Capital Fund), sub-items 27.1 (Advances made to meet unforeseen or extraordinary expenses as authorized by resolution WHA35.9, part C, para. 1(2)) and 27.2 (Advances made for the provision of emergency supplies to Members and Associate Members as authorized by resolution WHA35.9, part C, para. 1(3)). The Committee would no doubt agree to recommend that the Assembly delete those items and sub-items from its agenda.

In the case of item 24 (Review of the financial position of the Organization), on the other hand, changes were to be made in two of the item's sub-items: in sub-item 24.3 (Members in arrears in the payment of their contributions to an extent which may invoke Article 7 of the Constitution) it was the words "if any" that had to be deleted, because the Assembly was to consider that question; while in sub-item 24.4, at present entitled "Report on casual income", an addition should be made so that it would read: "Report on casual income, budgetary exchange rates and other adjustments to the proposed programme budget for the financial period 1986-1987". The Committee of the Executive Board to consider certain financial matters prior to the Health Assembly, which had met that morning, had considered not only the amount of casual income available to help finance the programme budget for 1986-1987, but also the question of budgetary exchange rates and other adjustments to that programme budget, and it would be submitting to the Assembly a single report on those three interrelated questions.

If the General Committee had no objection to those various proposals he would transmit the corresponding recommendations to the plenary session of the Assembly the following morning.

It was so agreed.

As regards the allocation of items to 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 meeting, namely items 1 to 20, 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 wish to recommend to the Assembly that the remaining items (items 9 to 20) be considered in plenary meeting as planned.

It was so agreed.

2. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

The CHAIRMAN drew the Committee's attention to the provisions of resolution WHA36.16 which limited the duration of the Health Assembly in odd-numbered years to as near to two weeks as was consistent with the efficient and effective conduct of business. The Executive Board had accordingly decided that the Thirty-eighth World Health Assembly should finish on Wednesday, 22 May 1985, at the latest (decision EB75(13)).

Turning next to the daily timetable prepared for the Assembly by the Executive Board (document A38/GC/1), he concluded that in the absence of objections the Committee approved the timetable in principle, subject to any alterations which might subsequently seem necessary.

The General Committee then drew up the programme of meetings for Tuesday, 7 May, Wednesday, 8 May, Thursday, 9 May, Friday, 10 May, and Saturday, 11 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, 9 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 10 and 11, a list which already contained 90 names, should be strictly followed and that 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, he would inform the Assembly of those arrangements at the next plenary meeting.

It was so agreed.

Regarding the Technical Discussions, which were to take place all day Friday, 10 May, and on the morning of Saturday, 11 May, the CHAIRMAN informed the Committee that Mr Mechaid Viravaidya, who had been appointed General Chairman of those Discussions by the Executive Board at its sixty-fourth session, would unfortunately not be able to take up that appointment owing to sudden illness. Faced with this unexpected last minute development the Director-General had been fortunate enough to secure the cooperation of Dr Maureen Law, who had agreed to take Mr Viravaidya's place at a moment's notice. He felt certain that Dr Law's experience, not only of the Technical Discussions but also of the running of the Organization, would enable her to ensure that those Discussions proceeded satisfactorily, and was confident that he was speaking for the entire General Committee in thanking her for agreeing to take on that task at the last minute. He would inform the Assembly of the matter at its plenary meeting the following morning. (Applause.)

The meeting rose at 17h20.
PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

The General Committee heard reports from Dr MAKUTO (Zimbabwe), Chairman of Committee A, and Mr ROCHON (Canada), Chairman of Committee B, on the first three meetings of those Committees. The General Committee then drew up the programme of meetings for Monday, 13 May, and Tuesday, 14 May, and in particular fixed its own next meeting for Monday, 13 May, at 12h30.

The meeting rose at 17h55.

THIRD MEETING

Monday, 13 May 1985, at 12h40

Chairman: Dr S. SURJANINGRAT (Indonesia), 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 to the General Committee that before embarking on the regular procedure to draw up the list of Members to be submitted to the Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board, the Committee was required this year, exceptionally, to propose to the Assembly the candidature of a Member to replace the United States of America which had surrendered its right to designate a person for the remaining two years of the three-year term for which it had been elected in 1984. He reminded the Committee that the purpose of electing the United States the year before had been to extend that country's previous three-year term by one year so as to adjust the normal cycle for one of its nationals to serve on the Board, and that it had been understood at the time that the United States would surrender its right to designate a person to serve on the Board after one year. In a letter dated 5 April 1985, the United States had accordingly confirmed to the Director-General the withdrawal from the Board of the person designated by it with effect from the end of the Thirty-eighth World Health Assembly.

Consequently, and in accordance with Rule 104 of the Assembly's Rules of Procedure, the Assembly should elect another Member for the remainder of the period during which the United States would still have been entitled to designate a person, namely, for two years. Moreover, in order to comply with the geographical distribution in force in the Executive Board, the new Member should belong to the Region of the Americas. It was for the General Committee to propose a candidate to replace the United States.

The Chairman reported that following the announcement he had made the previous Thursday at the plenary meeting in accordance with Rule 101 of the Rules of Procedure, he had received a suggestion putting forward the candidature of Ecuador, and asked members of the General Committee whether they had any other proposals to make. Noting that this was not the case, and in the absence of any objection to the candidature of Ecuador, the Chairman concluded that, in accordance with Rule 80 of the Rules of Procedure, the General Committee would transmit that country's name to the Health Assembly.

It was so agreed.

The CHAIRMAN then reminded members that the usual procedure for drawing up the General Committee's list of recommendations 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 Rules of Procedure of the Health Assembly. To assist the General Committee in the performance of its duties, the following documents were before it:

(a) a table showing the geographical distribution of seats on the Board by Region;
(b) a list, by Region, of Members of the Organization which were or had been entitled to designate persons to serve on the Executive Board;
(c) a list - by Region and in alphabetical order within each Region - of Members the names of which had been suggested following the announcement made by the President of the Assembly in 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 Executive Board, whose term of office would expire at the end of the Thirty-eighth World Health Assembly and who would have to be replaced, namely: for the African Region, Zimbabwe; for the Region of the Americas, Chile and Trinidad and Tobago; for the South-East Asia Region, Indonesia; for the European Region, France, Morocco and the Union of Soviet Socialist Republics; for the Eastern Mediterranean Region, Iraq and Pakistan; and for the Western Pacific Region, China and Malaysia.

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 up, by secret ballot, a list of candidatures that, should the Committee so desire, 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.

Mr MECHÉ (Ethiopia), observing that there were 11 seats to be filled and that the list of candidate countries whose names had been suggested (mentioned by the Chairman under (c) above) also included 11 names, asked whether it was really necessary to hold a formal vote in accordance with the procedure described by the Chairman, and whether that procedure could not be simplified.

Mr VIGNES (Legal Counsel) replied to the delegate of Ethiopia that, since the number of candidate countries was equal to the number of seats on the Board to be filled (11 in both cases), there was nothing to prevent the Committee from deciding to recommend to the Health Assembly the names of the 11 Members in question without further formalities, provided there was no objection to any of them on the part of members of the Committee and that no member wished to propose the candidature of any other country.

Professor MENACHAC (Cuba), having noted that the name of Indonesia appeared both on the list of outgoing Members (list (d)) and on the list of candidate Members (list (c)), asked for confirmation that this country was really standing for reelection.

The CHAIRMAN confirmed that such was indeed the case.

In the absence of any objection or other suggestion, he declared that the list of 11 suggested Members to which he had previously referred (under (c)) - and which included the names of the following countries: Australia, Canada, Cuba, Cyprus, Democratic Yemen, Federal Republic of Germany, Indonesia, Lesotho, Malta, Poland and Tonga - would be the list drawn up by the Committee in accordance with Rule 102 of the Rules of Procedure. In accordance with the provisions of that Rule, the list would be transmitted to the Health Assembly at least 24 hours before it convened for the purpose of the annual election of Members to be entitled to designate a person to serve on the Executive Board.

It was so agreed.

Dr TAPA (Tonga), speaking at the invitation of the Chairman, thanked the members of the Committee for the honour which they had done to his country in recommending to the Assembly that it be elected to designate a person to serve on the Executive Board.

He pointed out, however, that the present situation regarding the representation on the Board of the Western Pacific Region did not allow for a satisfactory rotation of the countries of that Region, to which Tonga belonged. Indeed, two seats on the Board occupied
by persons designated by countries of the Region were to be filled that year, but there would be no seats to be filled in 1986 and only one in 1987; it would be better if the Region were regularly able to designate a new Member each year for election by the Assembly. Tonga would therefore be prepared, if the Assembly were to follow the Committee's recommendation, to withdraw next year in order to permit another Member of the Western Pacific Region to be elected in 1986. In conclusion, he expressed the hope that his country would be re-elected at a future date to designate a person to serve on the Board.

Mr BOYER (United States of America) felt that the position taken by the delegate of Tonga raised an interesting but possibly difficult legal question. He recalled that at the beginning of the meeting, the Committee had agreed to recommend that the Assembly elect Ecuador in place of the United States for the remainder of its period of entitlement to designate a member of the Board, namely for two years. Would the situation be similar if it were necessary, next year, to replace Tonga, which would also have served on the Board for only one year?

Mr VIGNES (Legal Counsel) stated that the question raised by Mr Boyer following the stand taken by Dr Tapa touched on a legal problem that was difficult to solve. The gesture of Tonga was in fact intended to allow for rotation among Members of the Western Pacific Region in conformity with the spirit of Article 25 of the Constitution, which aimed to "facilitate the election of at least one Member from each regional organization in each year". As Dr Tapa had pointed out, the purpose of his country's renunciation of its entitlement after one year was to permit the Assembly to elect in every year a Member of the Region to which Tonga belonged. That election would be governed by the provisions of Rule 104 of the Rules of Procedure, which stipulated that should a Member surrender its right to designate a person to serve on the Board before the expiration of the term for which it had been elected, the Assembly "shall elect" another Member to replace it, but only for the remainder of the period to which the retiring Member was entitled. Thus, in the case in point, the 1986 Assembly could elect a Member to replace Tonga only for the remaining two years of its term of office, which would once again distort the cycle of annual rotation desired by the countries of the Western Pacific Region.

However, there was, in his opinion, a way of resolving the conflict between the spirit of Article 25 of the Constitution and the letter of Rule 104 of the Rules of Procedure. It would suffice for the 1986 Health Assembly, before proceeding to the election of the Member to replace Tonga, to decide to suspend the relevant provisions of Rule 104. It would thus be free to elect the Member to replace Tonga for three years, thereby re-establishing the smooth rotation amongst the Members of the Western Pacific Region which those countries wished to see.

Dr MAFIAMBA (Cameroon) expressed the hope that the spirit of solidarity exemplified by the gesture of the delegation of Tonga would continue to prevail in the deliberations of WHO. He further wished to take the opportunity to request the Secretariat to ensure the representation of China on the Executive Board on the same basis as that of the four other countries - the United States of America, France, the United Kingdom of Great Britain and Northern Ireland and the Union of Soviet Socialist Republics - whose presence on the Board was more or less permanent.

Mr MOHAMMAD (Nigeria) also wished to welcome the generous gesture of Tonga and the regional arrangements which that gesture would permit. He assumed that Tonga had taken this stand after consultations in the Regional Committee of which it was a member, and to which China also belonged. Like the previous speaker, he hoped that the presence of China on the Executive Board would be ensured on the same basis as that of the four other countries in question, whose nationals sat regularly for three years out of four.

Mr VIGNES (Legal Counsel) stated that it was correct, as the delegates of Cameroon and Nigeria had just recalled, that four of the countries which were permanent members of the United Nations Security Council had been regularly re-elected in WHO as Members entitled to designate a person to serve on the Executive Board after a break of one year. The interventions that had just followed Dr Tapa's statement nevertheless addressed two different problems.

In the first place, there was the question of the re-establishment of a smooth rotation amongst the Members of the Western Pacific Region on the Executive Board. That problem could be solved through the undertaking by Tonga, announced by Dr Tapa, to resign from the Board after one year, subject to the suspension next year by the Assembly of the problem clause in Rule 104 of the Rules of Procedure, as he (Mr Vignes) had earlier suggested.
The second problem, which was connected with the first, was that of the choice of the Member to replace Tonga in 1986. Responding to Dr Mafiamba, Mr Vignes said that the Secretariat was not in a position to give a guarantee concerning the election of any given Member. However, he was convinced that this question could also be satisfactorily settled at the regional level, through consensus in the Western Pacific Regional Committee, which would certainly wish to take account of the pertinent observations of the delegates of Cameroon and Nigeria.

Dr NAKAJIMA (Regional Director for the Western Pacific) wished to inform the Committee that the Members of the Western Pacific Region habitually engaged in informal consultations during the sessions of their Regional Committee in order to designate those Members whose candidatures would be put forward for the elections to the Executive Board; in recent years such designation had regularly been made by consensus. He was convinced that this would continue to be so in the future, and would not fail to inform the Regional Committee for the Western Pacific, at its next session, of the views of the General Committee of the Assembly.

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

After reminding the Committee of the programme of meetings for Tuesday, 14 May, decided at the previous meeting of the Committee, the CHAIRMAN requested the Chairman of Committee A to report on the progress of work in that Committee.

Dr MAKUTO (Zimbabwe), Chairman of Committee A, reported on the progress made in that Committee since the previous meeting of the General Committee.

Noting that the Assembly was advancing rapidly in its work, the CHAIRMAN invited members of the Committee, whose task it was to fix the date of closure of the session, to consider the question so that the Committee could take its decision at its meeting the following day, Tuesday, 14 May, at 17h30.

The General Committee then fixed the programme of meetings for Wednesday, 15 May.

The meeting rose at 13h15.

FOURTH MEETING

Tuesday, 14 May 1985, at 17h40

Chairman: Dr S. SURJANINGRAT (Indonesia), President of the Health Assembly

1. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

After hearing Mr ROCHON (Canada), Chairman of Committee B, and Dr MAKUTO (Zimbabwe), Chairman of Committee A, on the progress of the work of their committees, each of which had met three times since the General Committee's previous meeting, during which the programme of work of the Assembly for Wednesday, 15 May, had been fixed, the General Committee fixed the programme of meetings for Thursday, 16 May, and in particular its own next meeting for 17h30 on the same day.

2. DATE OF CLOSURE OF THE HEALTH ASSEMBLY

The CHAIRMAN reminded the Committee that it had agreed on the previous day to fix the date of closure of the Thirty-eighth World Health Assembly at its current meeting, and that the task was incumbent on it under Rule 33(g) of the Rules of Procedure of the Health Assembly. Having regard to the progress on which the chairmen of the main committees had just reported, he asked the members of the Committee to state their opinion on the matter.
Following an exchange of views with the participation of Dr BORGOÑO (representative of the Executive Board), Dr MAFIAMBA (Cameroon), Dr MAKUTO (Zimbabwe), Chairman of Committee A, Professor SENAULT (France), Mr JENNANE (Morocco), Mr MOHAMMAD (Nigeria), Dr REID (United Kingdom of Great Britain and Northern Ireland) and Dr HASSOUN (Iraq), the General Committee agreed to defer its decision on the date of closure of the Assembly to its meeting two days later on Thursday, 16 May, at 17h30, by which time, having again heard from the chairmen of the main committees on the progress of their work, it would be in a position to fix the date of closure.

The meeting rose at 17h55.

FIFTH MEETING

Friday, 17 May 1985, at 17h50

Chairman: Dr S. SURJANINGRAT (Indonesia),
President of the Health Assembly

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

After Mr ROCHON (Canada), Chairman of Committee B, had briefly reminded the General Committee that his Committee had completed its work the previous day, Dr MAKUTO (Zimbabwe), Chairman of Committee A, informed it of the programme of work his Committee still had to get through the following day to complete consideration of the proposed programme budget for the financial year 1986-1987, including item 22.3 of the agenda (Financial policy matters).

Observing that it was difficult to estimate with any accuracy the time still required by Committee A to finish that programme, the CHAIRMAN said that the General Committee was confronted with alternative dates for the closure of the Health Assembly, which could be fixed for the following day, Saturday, 18 May, or for Monday, 20 May. He asked the members to decide between those two dates.

After an exchange of views, in the course of which the DIRECTOR-GENERAL gave details of the timing of the meetings which had still to be held before the Assembly's work was completed, the General Committee fixed Monday, 20 May, as the date of closure of the Health Assembly. The Health Assembly would meet that day at 9h00 for a first plenary meeting, to approve the last reports of Committee A, and then, after a short suspension, there would be the closing meeting.

2. CLOSURE

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

The meeting rose at 18h15.
COMMITTEE A
FIRST MEETING

Tuesday, 7 May 1985, at 11h05

Chairman: Dr D. G. MAKUTO (Zimbabwe)

1. ELECTION OF VICE-CHAIRMEN AND RAPPORTEUR: Item 21 of the Agenda (Document A38/22)

The CHAIRMAN expressed gratitude for his election and welcomed those present, particularly the delegates of Kiribati, Brunei Darussalam and Saint Christopher and Nevis, 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 A38/22), in which that Committee had nominated Dr J. van Londen (Netherlands) and Dr A. Al-Saif (Kuwait) as Vice-Chairmen and Mr J. F. Rubio (Peru) as Rapporteur.

Decision: Committee A elected Dr J. van Londen (Netherlands) and Dr A. Al-Saif (Kuwait) as Vice-Chairmen, and Mr J. F. Rubio (Peru) as Rapporteur.

2. 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.

It was so agreed.

3. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1986-1987: Item 22 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II)

The CHAIRMAN drew attention to the information provided in the Journal on the manner in which Committee A would undertake its review of the Director-General's proposed programme budget, together with the Executive Board's report thereon, in accordance with the procedures recommended by the seventy-first session of the Executive Board and endorsed by the Assembly in resolution WHA36.16.

Under item 22.2 (Programme policy matters) programmes would be considered in smaller groups than at the Thirty-sixth World Health Assembly, and during the discussion he would refer to those groups as "major" programmes; "major" programme 13 (Disease prevention and control) would thus be subdivided into three parts. In accordance with resolution WHA36.16, in the discussion on each "major" programme the Committee would consider simultaneously: (a) major programme policy issues, including questions on resources allocation highlighted in the Board's report; (b) separate reports on individual programmes submitted by the Director-General; (c) questions of a specialized nature raised by delegates, including any possible resolutions.

If there were no comments, he would assume that that method of work was acceptable to the Committee.

It was so agreed.

1 See document WHA38/1985/REC/2.
GENERAL POLICY MATTERS: Item 22.1 of the Agenda (Documents PB/86-87; EB75/1985/REC/1, Part II, Chapter I; A38/INF.DOC./1; and A38/INF.DOC./2)

Professor ROUX (representative of the Executive Board) drew attention to the Executive Board's report on its review of the proposed programme budget for the financial period 1986-1987 (document EB75/1985/REC/1, Part II).

With regard to some of the main general policy matters discussed in the Director-General's Introduction to the proposed programme budget (document PB/86-87), the Board had shared the sense of conscience felt by the Director-General when, for the second biennium in succession, he had had to propose a budgetary ceiling which allowed for no growth in real terms. At the same time, it had understood that that was due to the existing world economic climate, and had appreciated the Director-General's efforts. That had led the Board to examine priorities in the allocation of resources. The Board had appreciated that it had been possible to redistribute resources within the Organization to provide a 4.2% real increase at country level; nearly 70% of WHO's resources were being allocated for country, intercountry and regional activities, and only about 30% for global and interregional activities.

In view of the large proportion of the Organization's regular budget resources allocated to the regions, the Executive Board had adopted resolution EB75.R7 requesting the regional committees to prepare and monitor the implementation of regional programme budget policies that ensured optimal use of WHO's resources at both regional and country levels in order to give maximum effect to the Organization's collective policies. The Board had reviewed a preliminary outline of those regional programme budget policies that might contain. 1

The regional programme budget policy concept was further described in paragraphs 59 to 60 of the Director-General's Introduction to the programme budget, in paragraphs 11 to 13 of the Board's report, and in the summary records of the Board's discussion on the subject. 2

The Board had emphasized that the success of national, regional and global policies and strategies for health for all would depend on having a critical mass of health development leaders. Therefore, as a matter of policy, the Board was in agreement with the Director-General's proposal to establish training or learning processes in health-for-all leadership. As the Director-General had emphasized, those would not be "classroom" events, the intention being to involve demonstrated leaders active in political, social, scientific, educational, religious, governmental, and community endeavour for health development, in addition to senior health-policy makers and executives, as well as those providing health care. If those efforts were to be worthwhile, as the Board believed, they would call for the redeployment of resources. As the Director-General had explained to the Board, he had formed a task force to elaborate the details of training for health-for-all leadership.

Dr NONDASUTA (Thailand) said that a "no growth in real terms" budget policy had been adopted by WHO because of the tight economic situation prevailing in the great majority of Member States; at the same time the least developed and the developing countries were faced with major discrepancies between the financial resources available and those required for successfully launching their health-for-all strategies. Important policy issues clearly arose from that dilemma.

The first and obviously urgent issue was that of optimizing the use of existing WHO resources. That of course required specific information on where, how, and by whom those resources were currently being used at all WHO levels. In that way, opportunities could probably be found of releasing substantial resources currently tied to unproductive expenditure and reprogramming them to meet the most urgent needs, particularly those of the least developed countries in launching their national health-for-all action. In the 1986-1987 programme budget it had proved possible to effect a 4.2% real increase at country level through reductions at other levels, and it was quite possible that that represented only the tip of the iceberg of possible reductions in existing established expenditures which could be mobilized to support health-for-all and primary health care requirements at the country level.

If such reallocations could be effected, preparations should begin forthwith at the regional and country levels to prepare the policies, strategies, priorities, mechanisms, processes and procedures for optimizing the utilization of the resources thus freed. Preparations such as government/WHO policy reviews, programme budgeting at country level and the development of managerial capabilities and systems including financial and performance

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1 Document WHA38/1985/REC/1, Annex 3.
accountability were all necessary; in Thailand the authorities fully realized the
difficulties of such preparations, having been engaged intensively for over three years in
the decentralized management of the WHO regular budget.

Thailand's experience led it to agree fully on the need for a frank evaluation of how
effectively WHO and other resources were being used at the country level in accordance with
health-for-all strategies. Such continuous evaluation inevitably led to the conclusion,
proposed by the Director-General and supported by the Executive Board, that regional
programme budget policies should be developed in line with countries' health-for-all needs.
Thailand supported the combination of a systematic and rational method such as programme
budgeting with a flexible organic management style, strategically adapted to the situation
and culture of individual countries and regions.

Whatever success Thailand had had in optimizing the use of WHO resources had been
achieved not only by courageous efforts to reduce unproductive expenses and to make the freed
resources available, but also by the action of dedicated health-for-all leaders who were
"inspired to aspire" and to implement innovations in primary health care with a view to
achieving health for all. Such strenuous changes and adaptation would require the training
and conditioning of national/WHO partners for a marathon effort rather than for a sprint.
Stress had often been laid on the need for a strong WHO programme coordinator's and
representative's office and for maximum use of national capabilities and resources.

The other policy issue that arose was how to find more external resources to meet
increasing requirements, but for the time being Thailand would support the policy of giving
priority to optimizing the use of existing resources.

Dr ROSDAHL (Denmark), speaking on behalf of the Nordic countries (Finland, Iceland,
Norway, Sweden and Denmark), welcomed the proposed programme budget for 1986-1987 as
presented by the Director-General. The Nordic countries fully supported the Director-General
in his endeavours to make optimal use of WHO's resources as reflected in the proposed
programme budget, which represented a realistic level of expenditure in difficult economic
times. They further agreed with the Executive Board that, in the face of the dilemma of the
need for a stationary budget as against ever-increasing and well-documented health needs, the
only solution was to take due account of priorities and to make the most efficient possible
use of all available resources, beginning with those of WHO itself.

The increased emphasis on allocations to countries was in line with the objectives of
strengthening national capacities to reach the goal of health for all by the year 2000, in
accordance with the Seventh General Programme of Work. On the other hand, increased
allocation of resources at the country level was obviously no guarantee in itself of an
improvement in the state of health, and it was therefore extremely important to introduce
machinery which could ensure that resources were spent in accordance with the agreed
guidelines of the health-for-all strategy. It was suggested that nearly 70% of the regular
budget should be allocated at the country and regional levels, and the Director-General's
proposal that each region should prepare a policy for its own programme budget, containing
inter alia a set of priorities, deserved the full support of the Assembly. The process of
preparing such a programme budget policy would not only compel countries and regions to
reconsider the best possible way of using available resources in times of economic restraint,
but would also mean that the Health Assembly would have a much sounder basis on which to
consider the biennial programme budget. The Nordic countries wished to intervene later on
the subject of regional programme budget policies.

The Nordic countries recognized that WHO's budgeting procedures would assume greater
importance as the budget became more decentralized, but believed that increased involvement
on the part of the Assembly and the Board in the monitoring and guidance of the regional
committees and countries with respect to their endeavours towards health for all should to a
great extent ensure global policy coherence. They were also open to any discussion of the
so-called "prior consultations" which might facilitate the drafting of the global WHO budget
in accordance with the needs of the regions and countries, on the understanding that any new
consultation procedure which might be proposed must be operational and constructive from the
points of view of the Member States and regions as well as of WHO itself.

The desirability of making the regions and countries more accountable with regard to
their allocation of resources, policy implications and compliance with the agreed global
strategies had been discussed at previous Health Assemblies. The Nordic countries agreed
with the Executive Board on the principle that government responsibility must go hand in hand
with government accountability, that the WHO budget was the collective property of the Member
States, and that no portion of it belonged solely to any one Member. Against that background
it seemed to be justified and reasonable to launch an experiment with a new kind of financial
audit in policy and programme terms in order to monitor the use of WHO resources in the
regions. The Nordic countries welcomed that initiative, in the belief that it would sharpen
the awareness of decision-makers and programme managers at all levels of their responsibilities for pursuing to the best of their ability the goal of making optimal use of WHO resources in striving to attain health for all.

The Nordic countries, while endorsing in general the content of the proposed programme budget, drew attention to the fact that the allocation for programme in the European Region had been further decreased, although to a limited extent. They could accept that decrease in the context of justified overall priorities, but would stress that the European countries should be left with reasonable resources so that WHO could remain in evidence on the European scene and thus retain its almost unqualified support in Europe; that was essential, for Europe paid almost half of the regular budget.

Mrs GARCIA (Cuba) welcomed the well-prepared documentation which provided a useful introduction to the general policies that would guide WHO's activities for the coming biennium. The Director-General's Introduction to the proposed programme budget was also most useful and focused appropriately on the economic difficulties being experienced by most countries of the world and, in particular, on the critical situation being faced by the developing countries, which was continuing to deteriorate. In such countries, which represented the majority of Member States in WHO, average economic growth rates had dropped to unprecedented levels over recent years. External debts and the servicing of those debts had reached such a magnitude that economic recovery had become virtually impossible. The picture was aggravated by two further factors: (1) inflation was swallowing up a large proportion of the gross national product leaving an increasingly narrow margin for satisfying urgent needs; and (2) official development aid from the highly industrialized countries, far from compensating for the deficits, stood at 1980 levels and, except in the case of a few contributors, was diminishing all the time. The general policies of WHO for the next few years would have to take account of those undeniable realities, realities which were clearly greatly impeding the achievement of health for all by the year 2000. The highly critical situations prevailing in some countries called for priority attention; achievement of the goal of health for all would be endangered if emergency methods were not adopted especially for countries where the economic situation was most serious - urgent decisions were needed, together with greater cooperation and a strong economic will to face the problems. It would be worthwhile for WHO to study how that difficult economic situation would impinge on the achievement of the goal of health for all. Her delegation believed that collective measures should be taken as a matter of urgency.

The efforts being made by WHO to stabilize the budget were appreciated. However, the financial situation was uncertain and predictions of financial and monetary movements inaccurate. The whole of the United Nations system was affected by the resulting currency fluctuations which had been such that it had already often been impossible to predict exchange rates. She considered that the programme budget, in that respect, showed evidence of serious and thorough study and her delegation supported the proposed measures.

Paragraph 14 of the Director-General's Introduction to the proposed programme budget dealt with the important question of technical cooperation among developing countries (TCDC). TCDC did not aim at absurd autarky, nor was it a utopian ideal; it was firmly based on the needs and the lessons drawn from such past experience of countries, making use of the very diversity of countries, in order to contribute to their development in a more balanced economic framework. Her delegation would appreciate further clarification of the statement made in paragraph 14 that "too much activism could destroy embryonic TCDC in its shell" and that therefore discretion was needed. Her delegation was concerned at the statement that "excessive expectations about WHO's role in TCDC for health" might have been "fanned by thoughtless rhetoric in too many circles" in case that statement might be interpreted as referring to the many resolutions adopted by the Health Assembly and the Executive Board which had laid stress on technical cooperation in health development, not to mention the important cooperation between developed and developing countries. Her delegation firmly believed that WHO should continue to work along the lines set down by those earlier decisions. The International Conference on Primary Health Care in Alma-Ata had recognized the importance of TCDC in the health field. The Plan of Action adopted by the United Nations Conference on Technical Cooperation among Developing Countries, held in Buenos Aires in 1978, was also a response to the challenge of finding effective measures for carrying out technical cooperation. While TCDC was the responsibility of countries themselves, there was broad recognition of the need for decisive supportive and catalytic action from the international organizations. Her delegation appreciated the consistent attitude in that respect shown by WHO and other international agencies and hoped that that attitude would continue.

One of the main objectives for 1986-1987, listed in the proposed programme budget, was to build up critical masses of health-for-all leaders in countries. Governments were being asked to take responsibility for studying and strengthening the proposal. Her delegation
believed the objective to be feasible and would support the exercise provided that it did not become a routine process producing bureaucrats and technocrats isolated from the daily realities facing the peoples. For the training of a critical mass of leaders it would not be enough merely to make use of the basic information provided in the "Health for All" Series documents produced by WHO; a broad mastery of all the interrelated factors affecting health problems in countries would also be needed. The Movement of Non-Aligned Countries had developed important activities to that end and would continue along those lines, seeking precisely to work out schemes that countries could make their own and that would bring a new dimension to their cooperation. The creation of a critical mass of health-for-all leaders was therefore important for any country, but called for the ability to act within the realities of the situation.

The proposed programme budget prudently and wisely stressed the need to make optimum use of WHO's resources; it was to be hoped that that would be achieved in all countries. In her own country, attempts were being made in that direction in close cooperation with the Regional Office. Evaluation of technical cooperation was also being developed with both the Organization and the Regional Office.

Dr WESTERHOLM (Sweden), speaking on behalf of the Nordic countries, said that with regard to the proposal that each region define a regional programme budget policy, ideally, the programme budget for Europe should correspond to the regional targets adopted in September 1984. The Nordic countries understood the difficulties involved in reorganizing the regional programme budget both in respect of the global budget structure and the need to ensure continuity in the programme budget process. They believed that a regional programme budget policy could be a valuable instrument for bringing about changes in that direction.

As regards the critical mass of health-for-all leaders, the Nordic countries considered the Director-General's suggestion an interesting initiative and looked forward to taking part in specific plans for its realization. Changes in legislation, organization, health services structure and allocation of financial resources were all important measures to facilitate and support the reorientation towards the health-for-all targets. But the most vital resource to mobilize was the cadre of professionally active persons within the health sector and, within other sectors of importance for improving the health status of the population - politicians, scientists, administrators and professionals of different kinds. In the Nordic countries there were almost one million persons working in the health services and, in addition, a great number of politicians and administrators of different levels had important decision-making functions for the health services and health development. The existing leaders within all those different categories were key persons for the realization of health for all and would have to become involved in the proposed training activities. The Nordic countries did not need to create a cadre of new leaders, but recognized that the existing leaders needed increased support through training in subjects related to the health-for-all strategy. The proposed international training courses could, therefore, play a valuable role in the development of national training programmes. Educational and training activities within Member States at national, regional and local levels had to be the basis for needed changes in attitudes, the learning of new skills and acquisition of new competencies. Continuing education of health personnel had during recent years come into new focus. The existing training system needed to be revised and strengthened and organizers of such training in universities and professional organizations needed to be motivated towards health-for-all-related training and made aware of already existing examples of successful activities.

For those reasons, the Nordic countries fully supported the elaboration of a detailed plan for the creation of a critical mass of health-for-all leaders.

Dr KHALID BIN SAHAN (Malaysia) informed the Health Assembly that he had had the opportunity of participating in the discussion on the proposed programme budget at the session of the Executive Board in January of the current year and his detailed views were recorded in the summary records of the session.

He supported the views of the Director-General expressed in his Introduction, especially the idea of discarding the agency-provided project approach and, instead, adopting a developmental type of cooperation wherein WHO support would be increasingly and truly identified with national needs and programmes. He welcomed the proposal that each region should establish its own regional programme budget policy to implement the new approach.

The managerial framework for optimal use of WHO's resources in direct support of Member States (document A38/INF.DOC./2) set out in general terms how the proposed changes were to be brought about. In particular, section 3 outlined the proposed role of the WHO programme

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1 Document WHA38/1985/REC/1, Annex 3, Appendix.
coordinator/national programme coordinator (WPC/NPC) under the new arrangements, whereby not only would his functions be enhanced, but he would be given formal authority to negotiate with the government on matters pertaining to programme formulation and the use of WHO's resources at country level. The Malaysian delegation welcomed the new arrangements since they would optimize the use of WHO's resources through country programmes which reflected the country's needs and priorities while remaining in line with WHO policies. The new arrangements would also provide for the close, continuing consultation needed to facilitate programme refinement and flexibility, and the focus of authority and accountability was clearly defined.

While technical support from the regional office would be available, the augmented role and functions of the WPC/NPC would make a great demand on his managerial skill and expertise. Not only must he be familiar with local conditions, but he must also be able to interpret WHO policies within the local context and to establish effective communication and consultation with national officers. In short, the WPC/NPC would be the most important link between WHO and Member States and therefore the selection of suitable candidates and their proper orientation would be crucial.

Since management responsibility and hence the accountability for the use of WHO's resources would increasingly shift to the government, it would be essential to ensure that the relevant government agency was able to discharge the additional function and that close rapport was established between that agency and the WPC/NPC to avoid delays and misunderstandings. National financial procedures and methods of accounting would have to be understood and national standards of accountability would have to be explained, but reports and returns should be kept to a minimum and be as simple as possible so as to reduce paperwork.

Many Member States would continue to rely on WHO to process international services since, through its worldwide contacts and technical credibility, WHO was in a special position to assist Member States in that very important area. His delegation welcomed the establishment of the "country support review mechanism" at the regional offices, described in section 4 of document A38/INF.DOC./2.¹ The formation of multidisciplinary teams, multidisciplinary reviews and the involvement of the WPC/NPC and government officials would not only enhance coordination of WHO's support but would also facilitate more effective integration of WHO-supported country programmes with the overall national health development programmes. Since intercountry and regional WHO activities would depend on the outcome of study of the regional "country support review mechanisms", it was logical that requests for headquarters' support in the form of interregional or global activities should come from regional offices, although that did not mean that headquarters could not make suggestions through the regional offices. The new procedures would facilitate communication between WHO and Member States and reduce misunderstandings which might arise if headquarters dealt directly with individual Member States.

Dr LIU Xirong (China) expressed his delegation's appreciation of the work which had gone into the preparation of the proposed programme budget, which reflected actual needs for the implementation of the strategy of health for all by the year 2000. It took into account the experience gained in implementing the previous programme budget and was in conformity with the Seventh General Programme of Work. It was therefore a better programme budget and was acceptable to his delegation.

The proposed programme budget put forward two new objectives, namely, the focusing of technical cooperation activities on the mainstream of national health-for-all strategies and the building up of critical masses of health-for-all leaders. His delegation considered the addition of those two elements to be necessary and timely. It therefore fully supported the Director-General's proposal to establish training courses in health-for-all leadership. It was to be hoped that many senior health manpower and management personnel could be encouraged to participate in such courses.

In view of the achievements and growth of WHO activities and increased costs due to inflation, the Director-General was to be commended on proposing a regular budget increase of only 6.52% over the 1984-1985 budget level, which, in fact, meant a zero increase in real terms. Yet, by making careful economies, the allocation to countries had been increased by more than 4% in real terms - that was no mean achievement. Finally, China wholeheartedly appreciated the fact that the Organization had decided to allocate 70% of its resources to intercountry and regional activities.

¹ Document WHA38/1985/REC/1, Annex 3, Appendix.
Dr NOORMAHOMED (Mozambique) expressed his appreciation of the proposed programme budget and its concordance with the Seventh General Programme of Work. At a time when the Organization's financial difficulties did not permit any overall real increase in its budget, the real increase of 4.2% at country level was particularly appreciated; it would ensure that those difficulties did not affect resources that countries so badly needed to improve their health situation, which still called for considerable efforts if the objective of health for all by the year 2000 was to be attained.

His delegation welcomed the decisions taken in implementation of resolution WHA29.48 at the global and interregional levels, which had strengthened technical cooperation. At the current time of world economic crisis that seriously affected the Organization's programme budget, further efforts in that same direction were required at regional and intercountry levels.

Country activities and cooperation were of paramount importance for the effective implementation of the health-for-all strategy. He therefore suggested that detailed studies should be made with a view to following the example set by some regions in reducing the considerable allocations to regional and intercountry programmes so as to place more emphasis on country activities.

The reduction of the staff and administrative costs of the regional offices for the benefit of technical cooperation activities, under resolution WHA29.48, was both possible and desirable, the aim being to simplify bureaucratic procedures and render the regional offices and their personnel more efficient and productive.

In the present economic situation, a more rational use of WHO's resources was a responsibility to be assumed by all Member States, which indeed shared responsibility for programme and budget resources as a whole. His delegation therefore supported all measures for the evaluation and control of activities at country level. In Mozambique, WHO resources were mainly used to implement the national strategy for health for all by the year 2000, and, in conjunction with the national budget, the national health plan.

His delegation also approved the allocation of nearly 33% of the budget to health system infrastructure, a key element in the health-for-all strategy and in the integrated execution of programmes.

Dr GLOTOV (Union of Soviet Socialist Republics) said that his delegation supported the emphasis placed in the proposed programme budget on the optimal use of the Organization's resources, upon which depended the successful implementation of health-for-all strategies. Many of the measures described in the managerial framework for optimal use of WHO's resources in direct support of Member States (document A38/INF.DOC./2)\(^1\) and in resolution EB75.R7, concerning regional programme budget policies, appeared useful and rational, although they still remained to be proved in practice.

The planned reduction of the allocations for intercountry and regional activities went against the principle of optimal use of resources. Intercountry activities could be a useful instrument in solving health problems while economizing on resources. Such activities should of course be properly planned, and the Organization should first look for the most rational types of intercountry projects to achieve optimum results at minimum cost. If countries were found to be giving priority to national rather than intercountry projects, that was no doubt due to the fact that the Organization did not always make the most rational use of intercountry projects and succeed in convincing countries of their effectiveness.

Programme and financial policies were closely interlinked, and, if optimal use were to be made of the Organization's limited resources, the scientific basis of its programmes should be strengthened. That point did not receive sufficient emphasis in document A38/INF.DOC./2 or in the introduction to the proposed programme budget.

Research should not be an end in itself but must be used to achieve WHO's basic aims within the shortest possible time. The scope of research should be broadened while at the same time planning, implementation and assessment of activities were improved. Those matters should be discussed in detail at the forthcoming sessions of the Executive Board and the Health Assembly. More attention should also be paid to the global functions of the Organization.

The prerequisite for the optimal use of resources was strict and systematic monitoring at all levels, especially by the Executive Board and the Health Assembly. Monitoring must include not only accounting, but also methods for improved planning, which might entail a modification of the form of presentation of the programme budget, as indicated in section 6 of document A38/INF.DOC./2. The information provided on the new presentation was not, however, sufficiently precise, and its introduction in the 1988–1989 biennium seemed premature. So important a matter should first be discussed in detail at the seventy-seventh

\(^1\) Document WHA38/1985/REC/1, Annex 3, Appendix.
session of the Executive Board and then at the Thirty-ninth World Health Assembly, taking into account lessons learned from the experimental use of the new presentation in the regions using the 1986-1987 proposed programme and including an assessment of the extent to which the new presentation met the requirement for strict monitoring at all levels by the regional committees, the Executive Board and the Health Assembly.

His delegation supported the proposal made by the Director-General and endorsed by the Executive Board in resolution EB75.R7 for the development of regional programme budget policies, although the Health Assembly and the Executive Board should make sure that such policies did not damage the unity of the Organization and that the policy of each region tallied with WHO's global policy.

He welcomed the proposals to build up a critical mass of health-for-all leaders, to which interregional and intercountry training seminars and exchange of experience in that field could make a significant contribution. Such courses could be organized in regional primary health care and manpower training centres, such as the Alma-Ata centre.

Replying to the question 6 in paragraph 71 of the Introduction to the proposed programme budget concerning budgetary and financial measures, he said that the measures proposed deserved full support, but did not go far enough. New ways of effecting internal economies should be found so as to limit the harmful effects of inflation on WHO's budget and curtail the significant increase in Member States' contributions.

The meeting rose at 12h35.
SECOND MEETING
Wednesday, 8 May 1985, at 9h35
Chairman: Dr D. G. Makuto (Zimbabwe)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1986-1987: Item 22 of the Agenda
(Document PB/86-87 and EB75/1985/REC/1, Part II) (continued)

GENERAL POLICY MATTERS: Item 22.1 of the Agenda (Documents PB/86-87; EB75/1985/REC/1,
Part II, Chapter I; A38/INF.DOC./1; and A38/INF.DOC./2) (continued)

Dr ACHESON (United Kingdom of Great Britain and Northern Ireland) said that the
Director-General was to be commended for the detailed and thoughtful analysis contained in
the Introduction to the proposed programme budget (document PB/86-87). It was particularly
helpful to have his evaluation of the general direction in which WHO was moving and of the
extent to which the agreed objectives from earlier programme budgets had been achieved. It
was only through that ongoing process of critical and frank analysis that the difficulties
could be overcome and the best use made of WHO resources. It was gratifying to note that not
only had a budget with no expansion in real terms been achieved, but that allocations had
been redistributed in the biennium to allow for a 4% growth in country programmes while
maintaining activity in other areas; that realistic approach set an excellent example for
other United Nations agencies.

The delegation of the United Kingdom was on the whole satisfied by the general
orientation of the proposals in the programme budget and by the apportionment of resources
among the main programme areas. It was important at that stage to continue to give priority
to building up health infrastructures which were an essential element for the successful
outcome of the health-for-all strategies, while maintaining and increasing allocations to
disease prevention and control and health promotion and care, as reflected in the budget
proposals.

The United Kingdom delegation shared many of the Director-General's concerns about the
use that was being made of WHO's limited resources. The Director-General had rightly called
for a heightened sense of accountability and for more sharply focused monitoring of
programmes by regional committees and of the work of those committees by the Executive
Board. Much more needed to be done by the regional committees themselves, and all Member
States should recognize the need for more rigorous scrutiny of both individual country
proposals and regional budgets. The United Kingdom delegation therefore welcomed the new
regional financial audit and endorsed the establishment of regional budget policies to ensure
optimal use of WHO resources at both regional and country levels, as well as the role of the
Executive Board as set out in resolution EB75.R7. In that connection, his delegation would
be co-sponsoring a draft resolution on the subject for consideration by the Committee at an
appropriate stage of its deliberations.¹

There was certainly a need to heighten awareness of the health-for-all objectives and to
generate the necessary enthusiasm and motivation among those responsible for planning and
implementing national health strategies to achieve those objectives. Although it was true
that people in all walks of life needed to be imbued with the health-for-all philosophy,
perhaps the most acute need at the present time lay within the health sector itself, and it
might be wise to begin by concentrating efforts in that direction. With regard to the
suggestion of using fellowship funding for training health-for-all leaders, the
United Kingdom would not be averse to the limited use of such funds for clearly defined
objectives, but would be less enthusiastic if unduly heavy inroads were to be made into the
fellowships programme which, despite its shortcomings, still constituted an essential element
for the health manpower development requirements of the majority of Member States. It would
follow the developments in that regard with interest and would consider participating in the
scheme once the issues had been further clarified.

¹ For text, see p. 64.
It would be noted that, although some of the target dates indicated for various programmes were still valid, others clearly needed revision to maintain credibility. The most important thing was that policies for achieving agreed objectives should be right and valid; target dates, however desirable, were secondary factors and should be set with a sense of realism and willingness to revise them in the light of experience.

Professor HUYOFF (German Democratic Republic) said that his delegation attached great importance to the Director-General's Introduction, the keynotes of which were undiminished commitment to the revolutionary global goal of health for all and deep concern about growing political and economic constraints. In his delegation's opinion the connection between disarmament and the performance of humanitarian tasks for the health protection of all mankind and for the establishment of greater social equity continued to be an issue which was within WHO's competence and could not be separated from the activities set out in the proposed programme budget. The problem of grossly inadequate funds should be considered in that context. Moreover, the target document of the European Region defined psychological and social stresses associated with the threat of nuclear war as an important health factor.

WHO continued to be an organization from which primarily global and catalytic action was expected. An analysis of its past activities, especially its positive achievements, proved that its deliberate and broad integration in the political, social, economic, cultural and humanitarian efforts of the United Nations system had created a spirit and atmosphere of solidarity which had made it possible to mobilize the necessary resources, and particularly the required manpower. The citizens of the German Democratic Republic considered it to be their right and even their duty, especially during the current year, to draw attention to the roots of a unique movement in human history - the anti-Fascist tradition of the anti-Hitler coalition, which had put an end to the most terrible war on record. From that point of view, it would be seen that the proposed programme policy was merely a compromise, based on the assumption that, despite all optimism, disarmament efforts would have no impact on the programme during the period under discussion and that the economic problems faced by the majority of Member States would not be solved in such a short space of time. With those reservations, his Government supported the proposed activities and the changes in WHO's programme policy: it considered that the shift of priority towards direct support for individual countries was an absolutely logical reaction which was, however, necessitated by the failure to solve certain global issues such as the New International Economic Order, disarmament and détente. It further considered that the principle of helping nations to help themselves was not invalidated or even weakened by that policy change: that was the meaning his delegation attached to the Director-General's remark that "filling empty stomachs" should not allow WHO to forget its true responsibility. It also supported the general objectives set out in paragraph 39 of the Introduction within the framework of the Seventh General Programme of Work.

On the other hand, special attention should be paid to the question of country programming, for it was not quite clear how appropriate national allocation and genuinely programme-based cooperation between countries could be brought about effectively. For the time being, his delegation thought that that type of technical cooperation was bound to be inferior in its long-term effects to any cooperation based on sound scientific findings and proved experience. That was why it regarded decentralized planning and budgeting as experimental steps needing thorough evaluation; they should be undertaken only if they proved more effective in enhancing the general programme and attaining the objectives emphasizing the establishment of national health infrastructures. The idea of building up a critical mass of health-for-all leaders in various institutions and at different levels deserved the widest support, and his country was prepared to make national resources available for that purpose.

Professor SENAULT (France) said that the Director-General and his staff were to be congratulated on the quality of the programme budget document, which was admirably clear and easy to consult. His delegation was generally in agreement with the new orientation proposed by the Director-General, namely, a horizontal instead of a vertical approach to budgeting and the allocation of the major part of available resources to country and regional programmes. It was sure that the Director-General, with his concern for strict budget control, was aware of the need to provide supervisory machinery for the rational and judicious use of resources, particularly in order to avoid bureaucratic accretions and duplication of effort.

In that connection, his delegation wished to have some clarification on the concept of health-for-all leadership. Although the proposal was acceptable in principle, it would be desirable to specify more precisely the methods whereby it would be applied; they seemed to be surrounded by a certain vagueness which was no doubt due to the novelty of the concept and...
would probably be dispelled with experience. Another point which his delegation wished to raise was the relationship of those leaders with national programme coordinators; it had always considered that the appointment of nationals, by nationals of the countries concerned, as programme coordinators might be a source of difficulty.

In conclusion, he noted with special interest two important decisions of the Board, requesting the Director-General: to define, together with the Regional Directors, a frame of reference for regional programming and evaluation of implementation, the Board being given monitoring functions; and to continue to promote the mobilization of the necessary additional resources.

Dr OLDFIELD (Gambia) expressed his delegation's full support for the new approaches which the Director-General had proposed for the optimal utilization of WHO resources. It had become obvious to all that available resources must be used in the most effective possible manner to meet the Organization's objectives. The main thrust in attaining the target of health for all was at the country level, and in the current financial climate the shift of major budgetary allocations to that level was indeed judicious. All WHO's efforts must be geared towards a rational promotion of national health strategies; yet strategies could only exist if there were clearly defined policies, and he would find it hard to believe that any country did not wish to have such a policy; the countries that did not have policies probably had difficulty with their planning machinery, which needed to be strengthened.

His delegation was interested in the proposals for the reorganization of WHO country offices. Indeed, the Organization had been late in recognizing that the functions of a coordinator, whether national or international, went far beyond those of a postal agency. Country offices formed a vital link between national efforts and the support that WHO could provide at the regional and headquarters levels. The coordinator must therefore be an efficient manager and must be given individual powers of decision within the guidelines that would be laid down. He was convinced that effective implementation of the proposals could only take place when the office of the coordinator became an integral part of the planning and management processes of the ministry of health.

Dr SYLLA (Guinea) congratulated the Director-General and the Board on the quality of the report on general policy matters; his delegation supported the conclusions and recommendations contained in the programme budget document and in the Board's report. He drew special attention to the serious socioeconomic and health situation of the African Region, where nearly all countries were facing obstacles to the implementation of their strategies as a result of the world economic crisis and such natural and man-made disasters as drought, floods, famine and armed conflict. Health problems were caused by a shortage of qualified health personnel, inadequate infrastructures and health systems, lack of systematic national management processes and, above all, scarcity of financial resources. His delegation therefore supported both resolution EB75.87 on regional programme budget policies and the proposal to train health-for-all leaders, a category of personnel which was essential for the provision of primary health care in Africa. He stressed that the training programmes should be adapted to specific regional characteristics if the work of those leaders was to be really effective.

Dr BATCHVAROVA (Bulgaria) said that, at a point when only a little time remained for the fulfilment of a task as important as that of achieving health for all by the year 2000, the question of how WHO resources should be utilized assumed vital importance. Speaking of resources in the broad sense of the word, it might be said that those of WHO, although not inexhaustible, were not really so meagre, but it was essential to find the best way of using them at all levels - national, regional and global. Member States were fully aware that the resources of the Organization were their own and that they had to utilize them as good housekeepers. The self-discipline to which the Director-General had referred was indeed the key that would help every Member State to derive the greatest possible benefit from the Organization. Her delegation believed that responsibility for monitoring the optimal use of resources rested with the Health Assembly and the Executive Board.

The documents before the Committee contained many important proposals; in particular, her delegation supported the idea of working towards a new model "Basic Agreement" between WHO and governments (paragraphs 2.20-2.22 of document A38/INF.DOC./2 outlining a proposed managerial framework for optimal use of WHO's resources in direct support of Member States). In 1976 Bulgaria had been the first country to sign a memorandum of understanding with WHO; several other countries had done so later. The experience thus acquired could no doubt help to find a better, fairly flexible, formula so that those

1 Document WHA38/1985/REC/1, Annex 3, Appendix.
memoranda provided support to countries for their health-for-all strategies. Paragraphs 2.9, 2.10 and 2.11 of the same document called for some clarification, since in their present form they gave the impression that WHO would assume the role of arbitrator with respect to governments' health policies.

Dr KOOP (United States of America) said his delegation welcomed the proposed programme budget, in which the Director-General was clearly advancing the policy priorities adopted by the WHO governing bodies. His Government had strongly supported the development and evolution of health-for-all strategies with their focus on primary health care, and was pleased to see those strategies advanced in the proposed programme budget. He was pleased to note a policy of zero growth, which met the concerns of the major contributors to the WHO budget about steadily rising budgets and the ability of all Member States to continue to pay their assessments. The proposed programme budget was particularly impressive in that, despite maintaining zero growth overall, the Director-General had been able to reorder priorities so as to permit an increase in programme growth of more than 4% at the country level, thus serving the interests of the developing countries as well as of the major contributors. His delegation would express some concerns about the proposed financing provisions and the calculation of cost increases at a later stage in the Committee's discussions.

His delegation supported the proposed new emphasis on ensuring that regional and country programme activities were in full accordance with the policies adopted by the WHO governing bodies. He agreed with the Director-General that some of the activities in country programmes appeared to be of doubtful relevance to health-for-all strategies. Governments should not see WHO's role as divorced from their own national health plans; the joint government/WHO policy and programme reviews in each country, proposed in paragraph 19 of the Introduction to the proposed programme budget, were very important in that respect. The emphasis on government accountability (paragraph 20) was also important. It included the need for regional committees to increase their monitoring of the implementation of country programmes and for the Executive Board to increase its monitoring of the work of the regional committees in relation to country programmes. He recognized that those proposals might not be received with enthusiasm by regional offices, since increased interest in the implementation of health programmes might lead to bureaucratic delays and complexity. While some of those concerns might be valid, the overall interest of Member States was to ensure that WHO's limited resources were utilized in the most efficient and effective manner. Detailed advance planning, oversight and monitoring, and evaluation of whether the tasks intended by the governing bodies were actually being carried out were all required. Such procedures should be normal for all organizations, but were particularly vital for an organization as large as WHO with such important social programmes at stake.

His delegation hoped that all Member States would support the implementation of the general procedures outlined in the Introduction to the proposed programme budget. Hopefully the procedures would not be so complex as to inhibit the flexibility and responsiveness that would be required of the regional offices in relation to most WHO programme activities. A reasonable balance could be struck, and his delegation was confident that the Director-General would find it.

Dr KITAGAWA (Japan) commended the well-prepared proposed programme budget, which his Government supported in general. As noted by previous speakers, the majority of Member States were facing a critical economic recession, and some countries, including Japan, were suffering from continued deficits in their national budgets and were making efforts to cut expenditures. He hoped that WHO would continue trying to make savings, while taking due account of priorities and utilizing the limited resources in the most efficient way, as described in the proposed managerial framework for optimal use of WHO's resources in direct support of Member States.

Dr MGENI (United Republic of Tanzania) said his delegation joined others in commending the Director-General and his staff on preparing the proposed programme budget so comprehensively. The content of the proposed programme budget document reflected the disturbing socioeconomic situation prevailing primarily in developing countries and, to a certain extent, in developed countries in respect of prospects for financial support in the struggle towards health for all. The appeal to the developed countries to exercise international solidarity in supporting developing countries overwhelmed by socioeconomic difficulties and negative environmental factors should be met with a sense of responsibility, accountability and appropriate action to conform with the proposed measures to ensure optimum use of WHO's resources, particularly at the country level. WHO was making efforts through the regional committees to prepare regional programme budget policies,1 and his Government

1 Document WHA38/1985/REC/1, Annex 3.
would do its best to comply with those policies for the sake of progress towards health for all - for time was running out.

He reiterated his country's support for the development of health-for-all leadership. Mental orientation towards the goal of health for all through primary health care had not taken off smoothly in his country, even for health workers who had dedicated their lives to the sick. A mental revolution was needed to change deep-rooted attitudes and replace the interventionist approach - reflected in the subconscious belief of "health through disease" - by the realization of the potential of the primary health care strategy. His country had accepted the philosophy of the development of health leadership and the need to sensitize leaders in a wide range of spheres - including politicians, social scientists and educationalists, religious and government leaders, and those of social communities and organizations for health development, in addition to senior health policy-makers and managers and providers of health care - to the importance of collaborating in support of the struggle for health for all.

He was pleased to note that the new strategy had started to take shape within the context of initiatives in technical cooperation among developing countries (TCDC), with the participation of some of the developing countries (namely, Cuba, India, Thailand, the United Republic of Tanzania, and Yugoslavia) in the first international colloquium on leadership development for health for all and TCDC, held in Yugoslavia in October 1984; a start had been made, and progress was gaining momentum. His country would support the Director-General's ambitious training programme, and would welcome the assistance of international organizations, including United Nations agencies such as UNDP, in organizing intercountry and interregional sensitizing colloquia for leadership development for health for all and TCDC.

Great efforts had been made in his country to orient influential individuals in various institutions and organizations towards the goal of health for all. Recently, efforts had been focused on the nongovernmental organizations. The prospects for success were by no means gloomy.

Professor BA (Senegal) commended the clear way in which the proposed programme budget had been presented. In view of the short time remaining for the achievement of the goal and the enormous difficulties that existed, his delegation wished to stress the need for WHO to continue to identify the most appropriate mechanisms for achieving optimum use of resources through better planning. The WHO programme coordinators and representatives had an important role to play in that respect.

It was also important to have health development leaders. Many countries had already established a number of mechanisms, such as national health councils and health development centres, with the aim not only of promoting intersectoral coordination and the training of health workers but also of furthering the implementation of health policies and strategies. That should be supported by other action, such as the strengthening of TCDC and, in particular, the exchange of information and experience. International solidarity and nongovernmental organizations would have an important role to play in that area, as would national responsibility and effective community participation.

An approach that was both flexible and disciplined would be needed in order to promote all those activities. Those two qualities might appear to be contradictory, but in fact they were complementary. Flexibility was needed for rapid mobilization of resources, but discipline was required for their optimum use. It was only through such action that the goal of health for all by the year 2000 would be achieved.

Mr NDOBE (Lesotho) said that the continued commitment of the Director-General and the Executive Board to the global goal of health for all was exemplified by the allocation of nearly 70% of the regular budget to regional and country levels at a time when the budget was being kept stationary. Member States were being presented with a real challenge to use their budget allocations in a way that matched the sacrifices with which they had been made and so that there would be visible progress towards health for all. His delegation supported the Director-General's proposal for training in health-for-all leadership. In Lesotho, primary health care workshops and seminars had already been conducted for teachers, traditional healers, traditional birth attendants, nursing leaders and representatives of nongovernmental organizations. Similar workshops had been held for personnel in various sectors of government. The groups had all been very receptive and had worked hard to identify their role in the implementation of primary health care and health-for-all strategies. Follow-up action was crucial in order to sustain their interest and enthusiasm and to ensure that activities supporting the Global Strategy were carried out. His delegation would like to see some national and WHO resources devoted to such follow-up action.
Dr LARIVIERE (Canada) joined other speakers in supporting the general policies outlined in the proposed programme budget. His delegation welcomed the new initiatives proposed to ensure optimum use of WHO's resources and fully endorsed the concept of regional programme budget policies, and noted with appreciation the Executive Board's contribution in that respect. WHO and its Member States had a collective responsibility to monitor the various ways in which WHO's resources were used to meet the needs of Member States. It was essential to know how and to what end resources were to be utilized, and why and where they were ultimately utilized. He welcomed the Director-General's proposals for a system that linked financial audit to the monitoring of programme decisions, and would be interested in seeing how effectively such a system could be applied at regional and country levels.

He agreed with those speakers who had expressed support for the Director-General's proposal for the development of a critical mass of health-for-all leaders. Since it was proposed that leadership courses would be financed in part by redeployment of resources at all levels of the proposed programme budget - which had not yet been approved - and in part by extrabudgetary resources, he would be interested to learn the likely overall cost of such courses and the expected impact on the proposed programme budget.

Dr BROTO WASISTO (Indonesia) supported the proposed programme budget. The excellent introduction could be regarded as an assessment of the global situation regarding the use of WHO's resources. Everyone was aware that the world economic recession was affecting the finances not only of individual countries but of world organizations, such as WHO. His delegation therefore recognized the need to maintain a stationary budget in real terms, and welcomed the 4% real increase in country allocations as a wise alternative. Every Member State would have to make optimum use of the available resources if the goal of health for all by the year 2000 was to be attained.

Indonesia had been selected as one of the pioneer countries for implementing a national health-for-all strategy using the primary health care approach. His Government and WHO had established a joint committee in 1983, one of whose functions was to review the use of WHO resources. He believed that optimum use of those resources would be achieved by that means. A new arrangement for the financial management of WHO resources was being introduced in 1985 which would increase responsibility and accountability within the Ministry of Health. Those actions were in accordance with the views expressed in paragraphs 19 and 20 of the Director-General's introduction to the proposed programme budget.

For the first time in his country, in the past two years there had been no increase in the Government's budget for health development. That had necessitated a reorientation of health development programmes, integrating activities aimed at reducing infant and child mortality, which were regarded as the main priority. The integration, which involved more community participation, would reduce organizational costs and increase service coverage. It would also shift the use of WHO resources in Indonesia towards activities of high priority.

Professor BERTAN (Turkey) praised the efforts made in preparing such a comprehensive document for the presentation of the programme budget proposals. Her delegation endorsed the proposed programme budget in general and welcomed the emphasis given to health system infrastructure and programme support - receiving, respectively, 32.62% and 21.83% of the effective working budget. However, the level indicated for the promotion of environmental health was rather modest to cover needs, at least in the developing countries.

Her Government fully supported the strategy for health for all by the year 2000 and recognized the need to undertake further action in the field of nationwide health education to encourage active community involvement, multisectoral collaboration, and a balanced distribution of health services and environmental health. Her Government welcomed the concept of training health-for-all leaders covering a wide range, from teachers and religious and village leaders to those in national and international institutions. Health-for-all leaders would doubtless pay an important role in increasing public awareness and the utilization of health services. Special attention would have to be paid to the strengthening of health services in the face of the increasing demands of the community.

Mr UMASHANKAR (India) said that his delegation appreciated the pragmatism and ingenuity shown in the preparation of the programme budget, which it fully endorsed. It hoped, however, that the policies enunciated would help to bridge the "health gap" existing not only between countries but within each country. The principle of self-reliance must continue to be supported.

His delegation felt that a continuous joint effort in assessing and monitoring health programmes would usher in an atmosphere of closer cooperation between WHO and Member States. It particularly appreciated the Director-General's initiative for the creation of a critical mass of health-for-all leaders.
It endorsed the proposals to improve the capacity of Member States to mobilize national and international resources in support of their national strategies and welcomed the increasing emphasis on Member States assuming responsibility for using WHO resources to develop and manage their own activities. In the case of India, the resources made available by WHO constituted only a small proportion of the country's outlay on health, but nevertheless were vital in enabling India to make the best use of its own resources.

His delegation also welcomed the emphasis on technical cooperation which could lead to earlier and more effective implementation of the health-for-all strategy.

The regional offices, while extending support to Member States, must be sensitive to the need for individual countries to develop their own capabilities for monitoring and evaluation.

Dr COHEN (Adviser on Health Policy, Director-General's Office), thanked delegates for their supportive comments on the general policy of the programme budget. The Secretariat was grateful to note that considerable support had been expressed for the guidelines for regional programme budget policies. The United States delegate had referred to reservations that had been expressed in certain quarters; the Director-General was aware of these. He (Dr Cohen) assured delegates that the Director-General's guidelines were based on policies democratically defined by the World Health Assembly, as all WHO policies were defined, after thorough debate, as well as on policies formulated by the Executive Board in accordance with its constitutional functions. The delegate of the USSR had mentioned that the guidelines might have been more specific but it was for each regional committee to develop its own individual programme budget policy on the basis of policies defined by the Health Assembly and the Executive Board, and in the light of the specific regional situation.

The United States delegate had warned against allowing the new policy-making system to produce a new bureaucracy. The Director-General's antipathy to bureaucracy was well known and his insistence on a dialogue between governments and WHO should go a long way to prevent the development of such a bureaucracy. The delegate of Cuba, too, had warned that the leadership development scheme might also produce more bureaucrats and technocrats; but the whole concept for health for all was inimical to bureaucracy and technocracy. The Director-General would, however, be on his guard against such dangers.

The delegate of Sweden had emphasized the further development of existing leaders. While this was an important part of the scheme, in many countries there was a great shortage of such individuals, particularly those with the capacity to lead a health-for-all movement. The delegate of France had asked what the Director-General meant by leadership development. He assured delegates that there was no intention of creating cadres proclaiming that they were health-for-all leaders, but if people were to take the lead in a health-for-all movement they must first understand what "health for all by the year 2000" implied and be motivated towards promoting it. For example, some people in important positions failed to understand that, as part of a health-for-all strategy, modern science and technology could be harnessed and applied appropriately within socially acceptable practices in particular countries. It was necessary to understand what was meant by policies and strategies to attain the goal of health for all and how to formulate and implement them; the Organization had published a wide range of documents on those matters.

The delegate of the United Kingdom had queried to some extent the use of fellowships for the leadership training scheme. The Director-General was well aware of the dangers of using money for fellowships in a far from optimal way, for example for training in distant lands which was locally available or of low priority in relation to a country's needs, as he had made clear in his Introduction to the proposed programme budget. Fellowships were mentioned as a possible source of resources so that countries and regional offices should not forget the health-for-all leadership scheme when considering the allocation of available fellowships.

The Director-General had set up a task force to prepare the leadership scheme, which would stress the development of national capacities. They were often present, if it was known how to look for them, and greater efforts had to be made to help them become part of the national leadership system.

The development of national institutions should not be confused with the question of the national WHO coordinators. That subject, raised by the French delegation, was being studied and would be reviewed shortly by the Regional Committee for Africa. The review would then be considered by the Executive Board in January 1986.

The delegate of Cuba had queried the Director-General's statement on TCDC in his Introduction to the programme budget. There should be no misunderstanding. The Director-General had always displayed enthusiasm towards TCDC and had consistently supported it. He would continue to do so vigorously. The purpose of his comments in the Introduction
to the programme budget was to draw to the attention of Member States the need for them to reach agreements among themselves on intercountry cooperative action, using WHO to support them as necessary, and to avoid any kind of supranational imposition of technical cooperation.

Dr KHANNA (Health-for-All Strategy Coordination), responding to comments on the proposed health-for-all leadership development initiative, said that the interdisciplinary task force set up by the Director-General had regional membership, which would enable consultations to be undertaken throughout the Organization; that consultation process had just begun. She proposed to share with delegates some of the preliminary ideas on which the task force was working.

Various delegates had referred to the gap between the policies collectively agreed upon and their implementation at country level. While there were indeed many issues which needed to be addressed, the health-for-all leadership development scheme would place emphasis mainly on strengthening or building human potential, addressing especially those persons at the policy and management levels in the national health and development processes who had both the opportunity and the responsibility to lead the health-for-all movement, at the national level and, through setting examples, at international level.

The aim was more than just to stimulate advocacy for health for all and broader than just strengthening the national managerial capacity; it was to enhance national capacity to lead and guide the implementation of health-for-all policies and strategies through critical review of constraints and issues and through directing and leading the crucial strategic steps that had to be taken in order to bring about the desired changes. These were broad in scope, dealing with cross-sectoral policies, the distribution and allocation of resources, the attitudes of health workers and committees, influencing other sectors and other partners in health, such as nongovernmental organizations and bilateral and multilateral agencies, and the mobilization of resources.

Emphasis was being placed on building national capacities. Strengthening WHO's own leadership, particularly at country level, was seen in the context of support required for national development.

While it was urgent to strengthen the existing leadership, as some delegations had stressed, over the long term efforts must also be made to develop the future generation of health leaders. Hence, it was proposed that the scheme should also initiate some activities aimed at the latter objective.

It was nevertheless expected that the initial activities would involve demonstrated and potential leaders in all fields of health activity, including senior health policy-makers, executives and those providing health care, as well as in the political, social, scientific, educational, religious, governmental, nongovernmental and community fields of endeavour. As the delegate of Cuba had cautioned, it was important that the process should not just create more bureaucrats but rather equip people involved with health problems to deal with a broad range of issues by adopting flexible approaches.

The task force had considered several approaches which had yet to be explored in depth. It was important to start with a few modest steps so as to find the most effective and innovative ways of achieving the objectives. Critical issues affecting the implementation of the national health-for-all strategies would be identified through careful review of national evaluation reports, joint country reviews of primary health care, and national consultation processes.

In order to promote clear understanding of the key issues in strategy implementation and utilizing the concepts and principles in the "Health-for-All" Series and specific country experiences, the Secretariat would prepare simple and dynamic information and learning materials. The usefulness of those materials would be tested in one or two experimental workshop-type activities for their appropriate adaptation for use at national and intercountry level. An important activity would be the identification and involvement of promising and leading institutions and centres, and progressive development of networking mechanisms among the selected institutions would be pursued.

Through an extensive consultation process at national, regional and global levels, potential and existing leaders would be identified and appropriate activities would be promoted and supported at national and intercountry levels to generate a clearer understanding of health-for-all concepts and implementation processes. Some of the ongoing regional and global activities which appeared to have particular relevance to the scheme, such as the colloquia on TCDC in health for all initiated by the Movement of Non-Aligned Countries, would be reviewed and used as appropriate.

It was intended that resources for the training scheme would be secured by redeployment of existing resources, but any additional resources required would be identified as the task force proceeded with its work.
It was recognized that the approaches would have to be innovated and that ultimately the process would have to be carried out at national level to suit particular national needs and objectives. Active participation and interest on the part of Member States was therefore essential. The aim was to spearhead the most effective and productive type of catalytic action.

The DEPUTY DIRECTOR-GENERAL was gratified to see from delegates' comments that WHO continued to be respected and praised for its work and its innovative strategies. With Member States' support it would be able to achieve some measure of success in fulfilling its fundamental aim by the year 2000. The constraints and difficulties should, however, be faced squarely. The Organization's highly decentralized character meant that its activities in the regions must be consonant with those carried out at the global level, and that its policies should be adequately reflected at the national and regional levels. It was also a fact that in some countries, especially those of the Third World, the health situation had gravely deteriorated, and considerable efforts were needed to recover lost ground. The judicious use of resources for programmes critical to Member States was crucial in that respect. It could be said that not all available resources, including human resources, were being mobilized at the regional and country levels, and further efforts were required to foster interdependence among national institutions involved in health-for-all programmes so as to use countries' real and potential resources to the full, bearing in mind the need for flexibility in adapting policies and programmes to countries' specific needs and situations. That called for qualities of vision and imagination and a willingness to take new initiatives and even risks.

The importance attached to country programmes was reflected in the real growth of 4% in allocations to countries. A more than 6% increase in contributions from other sources should bring that figure up to over 10%.

The Organization needed the cooperation of Member States to translate the policies formulated in the Executive Board and the Health Assembly into swift action at the regional and country levels.

PROGRAMME POLICY MATTERS: Item 22.2 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II, Chapter II)

The CHAIRMAN explained that, while the Committee would be discussing the agenda item by groups of programmes which he would refer to as "major" programmes taking them successively, the Executive Board, in its report, had grouped all those programmes under five broad categories. Thus the first of these "Direction, coordination and management" included two such "major" programmes, namely "major" programme 1 (Governing bodies), and "major" programme 2 (General programme development and management).

Dr BORGÔÑO (representative of the Executive Board) first invited attention to four important points stressed by the Executive Board relating to general programme policy and strategy issues.

The first was the inadequate managerial capacity in many countries, which would have to be given high priority as a prerequisite for the rational use of resources that the members of the Committee had repeatedly mentioned, and also for the establishment of a critical mass of health personnel, both leaders and health teams. The second point was the need to strengthen or initiate intersectoral action since health was conditioned by many other factors, and indeed by development as a whole, and all programmes should be viewed in that context. The question would certainly arise later in the Committee's work, especially as it was not easy to strengthen that action at any level and it was particularly difficult to do so in the developing countries at national level. The third point was the importance of promoting community awareness of health problems and active community involvement in the execution of programmes, that would attain their objectives and stand the test of time. The fourth point stressed by the Board was the need for wider dissemination and better use of information material within countries. It was very important that those four points, in particular, be kept in mind throughout the discussion of the programme budget.

Returning to the programmes under "Direction, coordination and management", he pointed out that, with the application of new working methods, the favourable exchange rate between the Swiss franc and the United States dollar and less use of temporary staff, it had been possible to reduce the budgetary allocation for the Health Assembly, without affecting its work. The Board had also placed emphasis on the coordinated support that the Board itself should give the Organization and especially the Director-General, in relation to strategies for health-for-all. The dialogue between the Executive Board and the Health Assembly was also naturally of the greatest importance in fostering participation by all countries and regions.
The Board had further stressed the valuable contribution that the Director-General's and Regional Directors' Development Programme could make, and was making, to greater flexibility in the use of funds, permitting the launching of innovative activities, the implementation of recommendations made by the governing bodies during discussion of the proposed programme budget, and the provision of catalytic aid in unforeseeable emergency situations.

Two other points discussed at length by the Board were its concern over the grave situation caused by drought and famine in Africa - which would be discussed subsequently in Committee B under a separate agenda item - and the Organization's role in relation to natural disasters. WHO, as the health arm of the United Nations, had a long-term coordinating role, rather than one of immediate relief. Its basic function was to prepare countries to deal with such disasters and help them to build up their regional, national and local infrastructure and develop intersectoral cooperation so that they could take swift and effective action.

Direction, coordination and management ( Appropriation Section 1; Documents PB/86-87, pages 49-70; EB75/1985/REC/1, Part II, Chapter II, paragraphs 17-24; and A38/INF.DOC./7)

Governing bodies (programme 1)

Dr REZAI (Islamic Republic of Iran), referring to the report of the Executive Board, (document EB75/1985/REC/1, Part II) said that, while he supported the proposal in paragraph 49 to update the 1970 report Health aspects of chemical and biological weapons, WHO, in collaboration with other international organizations, should take prompt action to ensure that chemical weapons ceased to be used.

Referring to paragraph 59 of the Board's report, he said that, given the deteriorating situation regarding malaria, if malaria research were hampered by insufficient funding the resurgence of the disease would become unavoidable. It was therefore necessary for research to be continued and for all countries in the endemic areas to organize a comprehensive programme using present methods of control based on primary health care. That presupposed that they were equipped with adequate health system infrastructure countrywide.

The CHAIRMAN informed Dr Rezai that there would be an opportunity to discuss such matters at a later stage in the debate.

Dr REID (United Kingdom of Great Britain and Northern Ireland) was gratified to note the savings of US$ 430 000 made as a result of the reduction in the length of the World Health Assemblies to two weeks in even-numbered years. In regard to odd-numbered years it was important to allow adequate time for discussion of the many topics involved. Nevertheless, it was important to keep the conduct of proceedings in the Assembly under review in order to achieve the most efficient and effective use of time, and so of money.

His delegation believed that the role and functions of the Executive Board had continued to evolve satisfactorily. There was now a constructive dialogue between the Health Assembly and the Executive Board, greatly helped by the contribution to debates in the Assembly by the Chairman of the Board and the other Board representatives to the Assembly. The continuing and constructive dialogue between the Board and the Secretariat also greatly assisted the work of the Assembly and of the Organization as a whole. His delegation considered, however, that the relationship between the Executive Board and the regional committees might benefit from some further development. It therefore welcomed paragraph 3 of the programme statement on programme 1.2. The mutually supportive relationship of the various governing bodies and between them and the Secretariat should, however, be a dynamic one and there should be a continuing effort to seek ways of improving it.

Dr BRAMER (German Democratic Republic) expressed his general agreement with all the programmes under "Direction, coordination and management", and with the increased responsibility given to the World Health Assembly for the key targets under the Global Strategy. The considerable increase in funds allocated to some Regional Directors was an interesting experiment which deserved careful evaluation. The increasing efforts for coordination at the global and interregional levels were in line with the comments made by his delegation in previous years.

Referring to the relationship between headquarters and the regions in regard to WHO's general programme development and management, he said that, while the regions should pursue a health policy meeting both the common and the special needs of the countries concerned, programmes carried out in the regions must be consistent with the general direction and orientation of WHO's Global Strategy. The German Democratic Republic considered that the main responsibility for the Global Strategy remained with the World Health Assembly and consequently with headquarters.
Dr BORGOÑO (representative of the Executive Board), replying to the comments made, emphasized the point made by the delegates of the United Kingdom and the German Democratic Republic regarding coordination and the relationship between headquarters and the regions, and more particularly with the regional committees. That had been an important element in the discussion and was relevant not only to coordination but to decentralization. Those comments confirmed the thinking in the Organization’s governing bodies.

WHO’s general programme development and management (programme 2)

Dr NONDASUTA (Thailand), referring to the managerial framework for optimal use of WHO resources, said that his delegation welcomed the development of economic strategies which would receive special emphasis over the coming biennium.

His own delegation had referred, on several occasions in the past, to Thailand’s experience in connection with the new managerial framework. His country had been involved since the end of 1981 in a process of decentralized management of its WHO programme, which had included the establishment of a special government/WHO managerial mechanism, with a very strict financial and technical monitoring component and documentation system, together with full authority for decision-taking in respect of programme planning, reprogramming, implementation, monitoring and evaluation.

Thailand had recognized and accepted full responsibility and accountability in that joint venture with WHO, which was the outcome of an agreement between the Director-General, the Regional Director and the Royal Thai Government, culminating in the Bangkok Declaration signed in October 1981. The first evaluation, conducted in June 1984, had shown that the managerial mechanism was functioning quite satisfactorily and that his country was starting to make much better use of WHO resources.

His delegation considered that the proposed new managerial mechanism contained all the elements of the managerial approach which was in the process of being implemented and developed in Thailand. The mechanism, process and procedures existing there were fully adapted to the national situation, and were, moreover, sufficiently flexible and dynamic to permit modification in the light of performance and circumstances; indeed, that had already successfully taken place. Compliance with nationally and internationally agreed policies, priorities and strategies constituted the fundamental criterion for programme planning and implementation, including selection of detailed activities. Other important criteria related to technical, social and economic relevance, as well as to the degree of community involvement and how that community stood to benefit from a given programme.

Joint government/WHO policy and programme reviews were being successfully conducted at the required intervals. The Seventh General Programme of Work, along with national development plans, represented the framework for programme planning procedures. As was apparent in WHO programme development since the inception of his country’s decentralized managerial process, the practical result had been an extensive self-managed primary health care core programme, backed up by a few other supportive programmes relating to health infrastructure and health science and technology. Research and development were key components of the programme in Thailand, and the reorientation of the health system to strengthen primary health care was a prime element in the strategy being followed.

He strongly endorsed the importance attributed within the new managerial framework to the WHO programme coordinators and representatives (WPC) as an essential element of the decentralized management effort. Thorough consideration had to be given to the WPC and his office as part of the national/WHO managerial system and to measures which would enable them to retain all the requisite independence and objectivity for fully efficient implementation of programme budgeting in accordance with accepted principles and criteria. That had been achieved in Thailand. His delegation would have a number of proposals to make, based on national experience, regarding all essential facets of the position of the WPC within the new managerial framework and the practical consequences to be taken into account.

In Thailand, decentralized management had resulted in more than 80% of its WHO country budget being allocated to direct financial cooperation, at the same time as international services were progressively shrinking. From his Government’s analysis, it appeared that the best use of WHO resources at the present juncture was in the financing and support of activities carried out within the country and largely in the community. Such financial cooperation included direct subsidy to village cooperatives, training, research and development, as well as extensive use of national experts and institutions, whereby the best national expertise could be mobilized at a very reasonable cost. It should be borne in mind also that that very considerable amount of direct financial cooperation extensively increased national responsibility and accountability, thus resulting in tight financial monitoring procedures and a state of constant preparedness for national and WHO audit.

1 Document WHA38/1985/REC/1, Annex 3, Appendix.
On the aspect of collaboration with the regional offices, he would join with the Director-General in emphasizing that the Organization had much more to offer than financial input. Technical collaboration should therefore be strengthened, and, even with a drastic reduction of WHO regional staff, he believed that successes had been achieved at country level in preserving and enhancing WHO's identity and in preventing the Organization from becoming purely a financing agency. In Thailand, that had been achieved as a result of the integrated partnership with the currently very limited number of WHO staff and of the harmonious and extremely effective style of the collaboration. It was also vital that the regional office itself should be in a position to offer an even higher measure of technical collaboration, instead of devoting large amounts of its time to the financial management of the country programme, including the decision-making which, under the new managerial framework, was being carried out at the country level.

It was apparent that both the regional offices and the countries concerned were faced with the need to adapt to changes of great magnitude arising out of the present situation. While a certain resistance to change was natural when confronted by an evolution possibly leading to entirely new situations, it was necessary for a serious effort of communication to be made. It was gratifying that, thanks to the Regional Director, significant progress was being made towards the development of such an efficient collaborative system, which included increased understanding of the nature of the management system and the current programme, with the acceptance of an integrated approach going beyond the structure of either the Thai health administration or of the Regional Office.

An essential question at regional office level was the role to be played by intercountry programmes, which called for scrutiny, particularly as part of the regional programme budget policy. He pointed out that Thailand was also fully involved in that development through its decentralized management effort.

His delegation was not as yet prepared to comment on relations with WHO headquarters in the context of the new managerial framework. So far requests addressed to headquarters by his Government under its country programme had been met. However, headquarters activities in Thailand often went far beyond the country programme and the government/WHO managerial mechanism was for the most part not involved either in the planning or in the implementation of most of those activities, in particular research; in fact, such involvement would require manpower and staff not at present available. If there were considered to be a need to streamline and coordinate headquarters activities in Thailand, which at the moment was not necessarily the case since work was proceeding satisfactorily, then a special managerial study would be called for in order to identify how the decentralized managerial mechanism could deal with that ever-growing activity.

His delegation wished to suggest, on the basis of national experience, that in any given country selected by means of realistic criteria a detailed situation analysis should precede any attempt to implement the new managerial framework. Some type of action, with step-by-step implementation, should be feasible in any country, since even a very modest and limited start could be a first step towards self-reliance. Further development of the new managerial framework should concentrate on the country and the regional office levels and on the essential relationship between them. The approach should considerably accelerate progress towards health for all by the year 2000.

Dr WESTERHOLM (Sweden) commended the Director-General on his thought-provoking introduction to the proposed programme budget for 1986-1987. The policies and programmes outlined therein could be of great importance for countries trying to achieve health-for-all targets, as that could only be done through a comprehensive health development strategy involving many different sectors, such as agriculture, education, water supply and sanitation, employment, housing and communication. Thus, the promotion of multisectoral action for health, emphasized both in the Declaration of Alma-Ata and in the Global Strategy for Health for All, should be given special attention in the work of WHO. The Executive Board itself had taken that view in its comments on the proposed programme budget under consideration. Accordingly, all efforts should be made to strengthen and develop the capability of WHO to support Member countries in taking that approach.

In addition to the many programmes and activities of an intersectoral nature proposed, a number of further initiatives were also worthy of consideration. There should be further strengthening of coordination and an improvement in the exchange of experience between projects and programmes of an intersectoral character, in order to facilitate the dialogue with representatives from other sectors and United Nations organizations, at global, regional and national levels. Efforts should be made to build on initiatives already undertaken in the area of intersectoral action for health through the creation of a comprehensive programme focusing on methods to analyse and implement multisectoral health development programmes and projects. Within that programme, special attention could be paid to possibilities and
constraints in assessing and evaluating both positive and negative health effects of economic and social development programmes — such as, for instance, the health impact of changing agricultural policies and urban renewal programmes — and to the mechanisms and methods for introducing the health dimension into public decision-making and policy formulation for various sectors, for example, by creating intersectoral health councils at national and local levels. Furthermore, empirical approaches could be developed regarding specific risk-reduction programmes and intersectoral action aimed at reducing inequalities in health between various socioeconomic groups of the population. Studies might be made, in the light of practical experience, of how to improve the capacity within the health sector for establishing a dialogue with other sectors, based on epidemiological analyses of health hazards, morbidity and mortality.

Intersectoral actions for health were of crucial importance if WHO was to mobilize successfully the total resources for health within countries and eliminate serious health hazards. It was accordingly important that WHO should strengthen those components in current and future budgets as well as when elaborating the Eighth General Programme of Work.

Mr TERENZIO (Inter-Parliamentary Union), speaking at the invitation of the Chairman, welcomed the opportunity to comment on the joint action undertaken by WHO and the Inter-Parliamentary Union (IPU). On 18–21 February 1985 the Inter-parliamentary Conference on Health and Development in the South-East Asia and Western Pacific Regions had been held in Bangkok under the joint sponsorship of WHO and IPU and at the invitation of the Thai group in IPU, and the conclusions and recommendations of that Conference were available to delegations.

It was particularly important, at a time when a number of international organizations were faced with difficulties, particularly of a financial character, that they should seek to demonstrate the realistic and effective nature of their action. Experience had shown that, in many fields, parliamentary and governmental action directed to the same ends, at world, regional and country levels, could make a useful contribution to that effectiveness. In that spirit, IPU, grouping parliamentarians of 103 countries, was organizing an increasing number of specialized conferences in cooperation with organizations of the United Nations system. Health and the place of health in development constituted an area of direct interest, involving the preparation of appropriate legislation and the financing of national health policies and programmes, as well as the evaluation of their implementation. Parliamentary representatives themselves could play a valuable role in support of such policies and programmes, especially with regard to primary health care, and that had motivated the Bangkok Conference, which had had the technical and scientific cooperation of WHO and had brought together members of the parliaments of 15 countries of the region, as well as parliamentary observers and representatives of organizations of the United Nations system.

It had been generally felt that substantial recommendations had resulted, combined with a real will to ensure their application. Only technical questions of concern to WHO had been considered, and discussions had taken place in a spirit of mutual understanding. The intention had been to ensure implementation, with WHO cooperation, at the national level of measures approved, and provision had been made for IPU national groups to inform IPU Secretariat of the steps taken and results achieved and for the dissemination of the information thus obtained. WHO participation had been warmly appreciated, and it was hoped that not only would the Conference lead to concrete results in the health field, but that it would pave the way for further IPU conferences of the same type with other United Nations organizations. He hoped that cooperation between WHO and IPU would continue in the future with fruitful results.

The meeting rose at 12h35.
THIRD MEETING
Thursday, 9 May 1985, at 9h00

Chairman: Dr D. G. MAKUTO (Zimbabwe)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1986–1987: Item 22 of the Agenda (Documents PB/86–87 and EB75/1985/REC/1, Part II) (continued)

PROGRAMME POLICY MATTERS: Item 22.2 of the Agenda (Documents PB/86–87 and EB75/1985/REC/1, Part II, Chapter II) (continued)

Direction, coordination and management (Appropriate Section I; Documents PB/86–87, pages 49–70; EB75/1985/REC/1, Part II, Chapter II, paragraphs 17–24; and A38/INF.DOC./7) (continued)

WHO's general programme development and management (programme 2) (continued)

Dr HAJAR (Yemen) joined previous speakers in commending the efforts made in the preparation of the proposed programme budget.

Yemen, one of the least developed countries, was following the primary health care approach to attain the objective of health for all. Encouraging results had been attained thanks to effective and committed community participation, and the support both of WHO and of other countries. He hoped that that cooperation would continue as it had begun.

He expressed satisfaction that the Technical Discussions at the current Health Assembly would be on the subject of "Collaboration with nongovernmental organizations in implementing the Global Strategy for Health for All". Those discussions would no doubt have a decisive impact on efforts towards the common goal.

He commended the way WHO was reviewing progress made, which should prove effective in ensuring optimal use of available resources. It demonstrated the flexibility of WHO. Yemen was one of the pilot countries chosen for the follow-up programme established by the Organization for the primary health care strategy. The project had enabled Yemen to orient all its programmes towards the health-for-all goal.

He supported the Director-General's view regarding the importance of training for health leadership.

Dr MGENI (United Republic of Tanzania) said that his country, like many others, had recognized that inadequacy of national managerial capacity had proved to be a handicap in the efficient and effective implementation of health programmes. One of the reasons for the inadequacy was that, although technocrats at different levels had been trained in the application of medical technology, it had not been realized that planning and management skills were equally important. It was only when the economic constraints of medical technology input, including drugs, had begun to impinge significantly on health resources that the importance of health economics had been recognized. His country had therefore now begun to introduce appropriate training for intermediate health administrators, including regional and district medical officers, public health nurses and health officers, in order to maximize their performance and ensure optimal use of the limited resources available. WHO had provided welcome support for those activities.

His Government had not established a national health council for strengthening intersectoral action but intersectoral cooperation did exist at various levels. There were established links between the Ministry of Health and the Ministries of Education and of Water and Energy, and the Ministry of Health was receiving strong support from the political party and the Prime Minister's Office. His delegation noted with interest the new approach proposed by the Director-General, with dialogues at country level between WHO and various government ministries, which should provide a further stimulus for intersectoral collaboration, with WHO playing a catalytic role.
He stressed the importance of disseminating health information and health education. It was customary to hear in WHO forums how countries were performing overall with regard to the attainment of the goal of health for all, but it was rare to hear a clear presentation of how individual Member States had proceeded within a specific set of guidelines recommended by WHO. While he was not advocating imitation, it would be most useful to learn how others had coped with the application of published WHO guidelines, and how those activities had helped them to improve the standard of health of their people. Countries should be able to learn from one another. Regional offices should endeavour to initiate a system of assessing success with the elements of primary health care, so that countries might learn from the success of others with similar geographical and socioeconomic conditions and similar health systems. A brief compendium of health data from a particular region or subregion would be useful for promoting intercountry dissemination of information.

Awareness of health problems was a crucial issue in many countries, the lack of epidemiological thinking being one of the main constraints. Health workers trained to look at wider public health concerns would be needed to synthesize the health problems of communities rather than individuals. Such workers were scarce and the introduction of epidemiology in the training of all health workers was of the utmost urgency.

It was vital to keep people informed regarding their current health problems. The strategy should be one of inspiring and motivating people towards responsibility, accountability and self-reliance in health. Appropriate communications mechanisms for this purpose would be needed. Realizing the importance of health education for primary health care, his Government had decided to decentralize its single health education unit to make information accessible to a wider segment of the population. He was pleased to report that assistance had been promised for this activity by WHO and by other international agencies and organizations, including UNICEF. As those efforts were intensified, it was inevitable that further resources would be needed.

His delegation supported the proposed programme budget for the areas under discussion.

Dr SAVEL'EV (Union of Soviet Socialist Republics) said that, with regard to programme 2.1 (Executive management), his delegation wished to emphasize the view expressed in the programme statement that evaluation should be an integral part of the management process and that each audit or evaluation should include, where appropriate, an appraisal of the efficiency and economy with which resources were used. That principle should be widely applied — not just for the financial period 1986-1987, but on a permanent basis. He welcomed the establishment of the Health for All Working Group under the chairmanship of the Director-General, which should stimulate coordinated cooperation at all levels with a number of countries with the aim of increasing national capabilities for solving problems arising in the implementation of health-for-all strategies. More attention would thus be paid to activities at the country level and to the use of resources at that level.

With regard to programme 2.2 (Director-General's and Regional Directors' Development Programme), he noted that a sum of US$1.6 million from the Director-General's Development Programme had been made available during the 1984-1985 biennium in accordance with the wishes expressed during the Thirty-sixth World Health Assembly for an increase in allocations to certain programmes. In that respect, he would state that his delegation supported the specific recommendations formulated by the Executive Board in its report on the programme budget for 1986-1987.

He noted with satisfaction that programme 2.3 (General programme development) included plans to improve further the Organization's information system, particular attention being given to cost-effectiveness in relation to the real needs of WHO and Member States. In view of the large sums allocated to the WHO information system, he asked for some details to be provided about the extent to which the computer capacity at WHO headquarters and in the regional offices was being used, and whether there was sufficient coordination and integration regarding its use. Computer technology was so expensive that constant attention should be given to the question of its appropriate use; the solution of that problem was of course an essential part of the whole question of the more effective utilization of WHO's resources overall.

Programme 2.4 (External coordination for health and social development) was an important sector of the Organization's activities. The Executive Board's recommendation for the allocation of additional resources from extrabudgetary sources for emergency relief operations deserved support.

Dr SULAIMAN (Nigeria) commended the efforts made in the preparation of the proposed programme budget and the informative nature of the Director-General's Introduction.

His delegation regarded the role of WHO programme coordinators and national programme coordinators - the first points of contact with Member States - as crucial in the managerial framework for optimal utilization of WHO's resources, and the programme budget document
should include reference to their role. The time had come for a clear definition of the functions of those offices, in respect of both national programmes and relationships with the regional offices.

It would appear that the Director-General's and Regional Directors' Development Programmes were essentially contingency funds. Proper guidelines for the use of those funds should be established so that Member States could derive maximum benefits from them, and in order to permit evaluation of those programmes.

The main constraint on the development of appropriate managerial processes in Nigeria was the lack of a national information system. Special support was required in that field, particularly for the training of staff and development of appropriate technology. Given the recent advances in the use of computers, it was timely for WHO to undertake training of nationals in preparation for the introduction of new information technology. The inclusion of a training programme in that field in the programme budget for the coming biennium would be welcomed.

Dr BISHT (India) supported the principles underlying the proposed programme budget and noted with appreciation the ingenuity exercised in making the various financial allocations in the face of a difficult economic situation. For a country the size of India, which had more than 30 states, each in itself as large as many Member States, and a population of over 700 million with a variety of social and cultural backgrounds, the attainment of the desired goal posed particular difficulties. India's seventh five-year development plan envisaged both consolidation and a judicious degree of expansion in order to meet the targets of health for all. There was a joint Government/WHO committee, of which the Regional Director was a member, whose functions were to ensure that national policies were relevant to the goal of health for all. The Prime Minister had given an assurance of his political commitment to the implementation of health policies.

India had committed a large proportion of its scarce national resources to its minimum needs programme, which was a strategy for achieving the goal of health for all, and to research and development in the health field. In order to achieve the desired results, it would be necessary to maximize efficiency. One means of doing that was to prepare guidelines for an integrated approach to technical, administrative and financial auditing. India had accepted the challenge and looked forward to support from WHO headquarters and the Regional Office in its efforts.

Dr MANDIL (Director, Division of Information Systems Support), responding to the questions raised by the delegate of the USSR on the Organization's use of computing and information systems, said that, in recognition of the importance of informatics, WHO had a master plan which identified the needs for informatics support, and the technological means and schedules for meeting those needs. The first phase of the master plan had covered the period from 1978 to mid-1984, while the second phase had started in mid-1984 and would continue until 1989. It consisted of two parts. The first dealt with the technical specifications of any admissible computing hardware or software which could be used by any part of the Organization. The aim was to maintain specific standards of informatics tools so as to avoid incompatibility. The standards covered both small-scale computing and larger-scale computing devices such as the ones used at WHO headquarters. The second part of the master plan consisted of the plans for the development of computerized support to any programme or division at headquarters or any regional office, or any of the various interorganizational secretariat divisions. The master plan was available and had been approved for implementation by the Director-General in August 1984.

WHO's main computing support at headquarters was obtained from the International Computing Centre, a United Nations cooperative of all the organizations based in Geneva. WHO's word-processing services were provided by equipment in individual offices and, recently, by micro-computers serving both data and word-processing requirements.

The regional offices had been increasing their use of computers for the past two or three years as part of the master plan. The Regional Offices for the Americas, for Africa and for Europe were already equipped with mini-computing and word-processing services. The other three regional offices were equipped with word-processing services and had begun over the past two years to introduce a number of services using micro-computers. The masterplan approach adopted and enforced throughout WHO aimed at optimizing the use of existing informatics resources and ensuring economies in the acquisition and uses of the computing or informatics services needed.

The master plan also looked ahead to future new types of requirements such as telecommunications within the WHO Secretariat and between the Secretariat and Member States. The Regional Office for Europe had already made a start in that direction and one headquarters programme, the vaccine production programme, was already linked by
telecommunication to seven geographically-spread collaborating centres working on high priority vaccine production.

The delegate of Nigeria had stressed the importance of national health information systems to the countries' health programmes and the need for training and methodological improvements. The Division of Information Systems Support at headquarters did provide, with the support of all the regional offices, a number of opportunities for such training, but he agreed that more was needed. Two international seminars on health informatics, aimed at middle-level management personnel in Member States, had been held in 1983 and 1984, and a third was planned for November 1985. The first had catered for some 14 participants from 12 Member States, and the second for 13 participants from 11 Member States. Because of the tremendous growth in interest and requests received for such training and the relevance of such training to Member States, it was planned also to convert the training material given at those seminars into self-study training material.

The DEPUTY DIRECTOR-GENERAL, replying to questions about the Director-General's and Regional Directors' Development Programme, said that the Programme had been established some years previously and its expenditure was always analysed in the programme budget. The criteria for use of the funds were very stringent, such as supporting programmes and projects which had not originally been budgeted for but which might have innovative qualities or potentiality. The Director-General had always adhered to the criteria, which had on one or two occasions been presented to the Executive Board through the programme budget documents. A consolidated document had been submitted to the Programme Committee of the Executive Board and would be made available to the delegate of Nigeria if he so wished.

It might be a good idea if the efforts of the regions were devoted not only to mobilizing resources for the Programme, but also to seeing that they were well spent. He therefore suggested that not only Nigeria, but other countries too, should ask the same questions at the regional committee level so as to satisfy themselves that the funds were being spent according to the criteria laid down by the Board and the Director-General.

Dr BORGONÓ (representative of the Executive Board) said that the programmes under "health system infrastructure" represented approximately 32% of the regular budget, a figure which indicated their importance. The total sum involved was about US$ 181 million.

The section consisted of a complex set of interrelated programmes and should be discussed as a whole, although they would be taken up one by one. Generally speaking, the Executive Board wished to emphasize that it recognized that there had been the political will to develop a policy of primary health care, but that implementation had been extremely slow. Several reasons had been suggested for that slowness and some had already been mentioned earlier in the Committee's discussion when stress had been laid on the need for better managerial capability in countries and the importance of the health-for-all leadership scheme. At the same time, the Board had stressed the need to strengthen the position of ministries of health within national administrations, especially in view of the importance for health programmes of intersectoral linkage.

Recognizing the importance of good assessment and knowledge of the health situation, the Board had commended the reorientation of programme 3.1 (Health situation and trend assessment). It was important to provide countries and regions with support in obtaining basic information which would be complete and reliable, so as to lead to a correct diagnosis and appropriate handling of the situation. It was recognized, in that connection, that the WHO Weekly Epidemiological Record had been improved and had proved to be a useful tool.

Programme 3.2 (Managerial process for national health development) had been discussed at length in the Board, especially in connection with the use of nationals as WHO programme coordinators. The experiment in that regard was under evaluation and the Board hoped to receive the report on it shortly.

The importance of health systems research (programme 3.3) had been stressed and, particularly, the lack of funds for it. Such basic research was important for developing good policies and norms and workable methodologies. The Board had stressed that countries must incorporate health systems research in their health strategy at national level so as to provide basic information for the decision-makers.

As regards programme 4 (Organization of health systems based on primary health care), the importance of intersectoral coordination could not be over-stressed. The Board had expressed its satisfaction with the joint effort of WHO and UNICEF in the activities of that programme.

Health manpower (programme 5) was particularly important. The Director-General had already spoken of the need to develop a critical mass of personnel not only to implement the
strategy but also to attain the goal of health for all by the year 2000. Emphasis should therefore be placed on the complementarity of all health professionals in health care and on the optimal use of the totality of health manpower. Career development and incentive schemes for health personnel and flexibility in the employment conditions for women should also receive particular attention. It was essential to support all national efforts for the training of a critical mass of personnel.

The Board had stressed the need to strengthen the programme on public information and education for health (programme 6), so as to create greater awareness and stimulate social responsibility, and to improve the quality of health promotional information reaching the general public. At the same time there should be encouragement to pay greater attention to healthy life-styles. Publications such as World Health would help in that respect.

Health system development (programme 3)

Professor FORGACS (Hungary), stressing the importance of monitoring and evaluation for the health-for-all strategy, pointed out that it was difficult to compare the data from different regions and countries without a unified indicator system. The meaning of the indicators could not be properly determined without well-trained manpower, whence the stress on manpower training in paragraph 13 of the programme statement. It would also be advisable to establish a network of intraregional and interregional centres which could analyse the comparability of data and also provide training in that field.

The newly introduced thematical issues of the World Health Statistics Quarterly were of great help in information transfer.

Professor HUYOFF (German Democratic Republic) expressed his delegation's agreement with the Executive Board's comments on health system development and the organization of health systems; they formed a sound foundation on which to base the biennial programme. At the same time, the variation in the degree to which Member States could implement their strategies, mainly due to inappropriate distribution and utilization of resources, must not be forgotten.

In order to concentrate on the establishment of well-functioning health care - not medical services - designed in a flexible manner so as to cope with demands that were very varied but often similar in different countries, health systems research was a necessity. His delegation considered such research to be the key to laying the foundation of a national health infrastructure; it could provide the tools for interweaving epidemiological information, research and other information on health and related conditions with the need for the proper use of resources and, finally, the evaluation of results. For that reason he wished to draw attention to the need not only to coordinate health systems research (programme 3,3) with activities under programme 7 (Research promotion and development), but to look constantly for ways of incorporating such research into all major programme activities so as to give practical effect to newly acquired knowledge. He thus welcomed the Board's suggestion (paragraph 31 of its report) that the Director-General might wish to consider an adjustment in the area of research by means of his development programme. A further suggestion might be to request a review of the various programmes to ascertain whether they included a health systems research component and in order to put an end to any duplication, and thus identify resources while increasing the effectiveness of the programme.

Aware as it was of the problems involved in formulating health legislation in support of health policy, his delegation welcomed the emphasis on comparative studies of trends in health legislation (programme 3,4). It was also prepared to offer its expertise to the technical working groups referred to in paragraph 9 under that programme.

Dr HASSOUN (Iraq), commending the programme and policies before the Committee, particularly welcomed the emphasis placed on the training of a critical mass of health-for-all leaders. He appreciated the efforts made by the Director-General and the Regional Director to reopen the Regional Office in the Eastern Mediterranean Region and welcomed the appointment of the new Director at what was a critical stage in the implementation of WHO's programmes in Iraq.

He stressed the importance of the WHO Weekly Epidemiological Record; he hoped that its coverage would be extended to other diseases with greater participation by Member States so that all necessary information could be provided on the epidemiological situation in various countries.

Dr QUBEIN (Jordan) said that the Jordanian Public Health Act 1971, recognized that health was the right of every citizen and that the Ministry of Health was fully responsible for all health matters. The national health policy was an integral part of the overall socioeconomic development plan for 1981-1985. The national health strategy reflected national health policy, and the Government was politically committed to achieving the goal of
health for all. There was full and continuous coordination and collaboration between the governmental and nongovernmental sectors.

His Government appreciated the full cooperation established with WHO, both at headquarters and at the Regional Office for the Eastern Mediterranean, as a result of which the country's needs were being met by the provision of experts, know-how and financial and technical support. New administrative arrangements had been adopted within the Ministry of Health; for example, the directorate for preventive medicine had been modified and now catered for all aspects of primary health care services. Legislation, too, had been developed to include the concept of primary health care and the strategy for health for all by the year 2000. Regarding health systems research, a study was shortly to be carried out on primary health care services. A research institute had also been established and cooperative links were being developed with universities.

Dr KLIVAROVA (Czechoslovakia) expressed her delegation's support for programme 3 (Health system development). Her Government submitted all the data required by headquarters for health trend assessment under programme 3.1, and participated in all WHO evaluation exercises. It took particular interest in programme 3.2 (Managerial process for national health development) and was prepared to share its experience in that field. While she welcomed the information given on all programmes for health management and health systems evaluation, the practical aspects of implementation were not described in sufficient detail. Czechoslovakia possessed a managerial system that had proved its worth over a number of years, and would welcome an opportunity for full use to be made of its national centres and experts in the evaluation of WHO's programme.

Regarding health legislation, Czechoslovakia had developed a set of legislative provisions and a basic law on health, and could make the relevant information available to other countries.

Mr UEMURA (Director, Division of Epidemiological Surveillance and Health Situation and Trend Assessment), replying to the question raised by the delegate of Hungary concerning the comparability of information, especially indicators, said that the approach was to support Member States in the selection of indicators to suit each country's specific needs, while reviewing the more commonly used indicators for purposes of international comparability. Uniform definitions and procedures needed to be established to facilitate such comparability, and they would also be useful for national purposes. Indeed, in defining indicators, WHO drew on national expertise, including that of the collaborating centres.

He recalled that the Health Assembly had adopted a series of indicators for global monitoring and evaluation of the health-for-all strategy. Countries had already used the indicators in the first progress reporting round in 1983, and the first national evaluation reports were being conveyed to the regional offices in 1985. To facilitate that task, a common framework and format had been prepared. While it was true that some indicators were not yet fully standardized, it was hoped that the accumulation of national experience would lead to universally acceptable, practical definitions that would assist in evaluating the Global Strategy.

Dr NUYENS (Health Systems Research), replying to the comments made by the delegate of the German Democratic Republic concerning the need for coordination in health systems research, explained that such research was now deliberately, by decision of the Organization, included in the different technical programmes. An identification exercise carried out in preparation for the Programme Committee of the Executive Board, in October 1984, had shown that such research was being developed not only in programmes under health systems infrastructure, but also in those under health science and technology. The relevant document could be made available for those interested (document EB75/PC/WP/4).

As a result of that decentralization of health systems research, the necessary coordination, information exchange and joint methodologies were being developed at all levels. At the global level, for instance, the Advisory Committee on Medical Research, with its subcommittees, was endeavouring to develop a common approach. The Research Development Committee and, in particular, the Core Group on Health Systems Research were seeking to ensure the necessary exchange of information between the various health systems research activities. In addition, there was ad hoc coordination of plans of action in areas such as training and indicators.

Dr OTOTO (Ghana) considered that the concept of developing a critical mass of health-for-all leaders was perhaps the most significant development since the Declaration of Alma-Ata in 1978. After five years of national efforts aimed at developing a system of health care delivery that would ensure equitable distribution of health services based on the primary health care approach, experience had shown that overall emphasis had been placed on
the eight components of primary health care without proper backup by adequate development of organizational support aspects, including intersectoral cooperation and community participation. That had occurred as a result of the apparent lack of awareness of what should be the nature of the goal of health for all as well as of the full implications of primary health care. Such a lack of understanding could be perceived among the highest echelons of the health sector, as well as among leaders in other sectors, such as the economy, universities and public opinion.

It would appear that over the years, education of the public and of professional and political leaders in the primary health care approach and the organizational needs for establishing an effective primary health care system had not really been carried out as it should have been, resulting in inadequate allocation of financial resources and relegation to the health sector alone of the responsibility for developing primary health care without the support of the total economy. Primary health care constituted a community development tool, which should accordingly be developed on the basis of such full support, and that was the context within which the Director-General's idea of developing a critical mass of health-for-all leaders should be seen.

That development should, however, take place within the framework of the managerial process which was essential to any sustained primary health care programmes and which should have its roots in the community through the identification and analysis of community needs around which primary health care programmes could be evolved. Health-for-all leaders should thus be seen as responsible for developing human, financial and material resources and also bringing about an integrated approach to developing primary health care programmes based on recognized community needs as part of a community development effort.

WHO should, with the goal of health for all in view, organize itself in such a manner as to provide assistance to the health administrations of its Member States in developing a capability: for identifying and analysing community needs and educating and working with the other sectors of the economy, community authorities and leaders of public opinion; for applying managerial competence in the development of programmes, from the community level to the district and national levels; and for developing managerial absorption capacity to ensure the efficient use of available resources. The programme budget for 1986–1987 should accordingly provide resources for those developmental activities calling for WHO assistance in the form of consultancies, training materials and other educational materials, and equipment for programmes and to meet operational research needs.

(For continuation, see summary record of the fourth meeting, page 40.)

Organization of health systems based on primary health care (programme 4)

Dr SAVEL'EV (Union of Soviet Socialist Republics) believed that programme 4 was one of the most important being undertaken by the Organization. He did not think, however, that the programme statement in the budget document adequately reflected the establishment and development of primary health care services as an element of the State health service. Furthermore, a reduction of almost 5.5% in real terms in the financial allocation for that programme could be noted. The statement contained a number of unduly broad and, at times, unjustified statements, such as the reference in paragraph 5 to generally slower progress than desired. He felt obliged to point out in that connection that a number of Member States had experience in solving problems of that type; their achievements should be duly made known. Again, paragraph 13, contained a reference to a worldwide economic crisis. While an economic crisis undoubtedly existed in many countries, it should not be assumed that it was worldwide, greater caution should be exercised in future in expressing that type of idea and in coming to that sort of conclusion.

Health manpower (programme 5)

Dr MELLBYE (Norway) believed that the view embodied in the programme statement regarding the need for radical reorientation of the skills and aims of health manpower throughout the world if health-for-all programmes were to be a reality by the year 2000 was applicable to all the health professions in all countries, developing and developed alike.

It would appear that so far the education and training given to health personnel had not produced a sufficient number of professionals who were geared, intellectually, emotionally and mentally, to the health-for-all concept. That state of affairs was not surprising since, as always, health personnel were naturally moulded in the stamp of the older generation responsible for their training, and current rapid developments further intensified that imbalance, with the result that health training was losing relevance to the world of today not to mention that of the year 2000 and beyond. Consequently, his delegation supported the Director-General's programme proposals aimed at achieving reorientation in the teaching of
health personnel in all categories and at all levels, in order to familiarize them with the knowledge, techniques, understanding and indeed spirit of solidarity which were prerequisites for the achievement of health for all. Those should, in his opinion, be the objectives and targets of the health manpower development programme. His delegation endorsed that programme and would welcome its dynamic expansion in the years to come.

Dr NJINJIOH (Cameroon) commended the Director-General for his brilliant and realistic budgetary proposals, which were in keeping with the spirit of the Cameroonian Government's New Deal policy.

His delegation endorsed the somewhat ambitious objectives of WHO in the field of health manpower, and fully agreed with the analysis provided by the Director-General of the prevailing situation in the developing countries in that regard, characterized by inadequacy in terms of both quantity and quality, concentration in urban areas, and inadequate career structure and incentives. It was imperative to introduce and implement a well-planned manpower training policy. His own Government had accepted that challenge and had embarked on the intensification of training of medical and paramedical personnel of all grades. His delegation was gratified to note from the proposed programme activities that cooperation with WHO in that venture could be expected.

In that connection, he expressed appreciation for the recent visit to his country by a WHO mission from the Regional Office, and expressed the hope that further such exploratory missions would be instituted with a view to the setting up of a national health development centre in Cameroon. His Government had already requested WHO collaboration in developing the postgraduate programme at the University Centre for Health Sciences in Yaoundé.

Dr LIU Xirong (China) stated that his delegation was in favour of the proposed health manpower development programme and appreciated the work accomplished by WHO in that area. The urgent task of improving the quality and number of personnel with adequate professional skills and knowledge of community medicine, and true devotion to their work was of the greatest importance and directly affected the development of action towards health for all. He therefore welcomed the importance attached by the Organization to health manpower and considered that the two main thrusts of the programme - the managerial process and formation of health personnel - were rightly emphasized. He expressed the hope that, through the common efforts of Member States, progress could be achieved in those directions in the course of the biennium. In view of the existing shortage in many developing countries of health personnel and of teachers for them, WHO should devote increasing attention to teacher training in those countries. He hoped that seminars and workshops would be organized on a regular basis in order to facilitate exchange of experiences between Member States.

His Government was particularly interested in the formulation of manpower policies, effective utilization of trained personnel and continuing education. It would therefore welcome an exchange of experience with other countries, and hoped that WHO would help Member States to compile and arrange teaching materials.

Mr LUPTON (United Kingdom of Great Britain and Northern Ireland) said that the United Kingdom, as one of the largest recipients of WHO fellows, agreed with the importance given to rationalizing the use of fellowships through the development of planned programmes. He understood that the Executive Board would be laying down criteria for the granting of fellowships, and his Government awaited its recommendations with interest. The general experience in the United Kingdom was that while there might have been minor shortcomings in its overall operation, the programme had provided a valuable resource for learning how other countries were tackling problems and in acquainting themselves with techniques used elsewhere. His delegation was convinced that the programme made a great contribution to raising standards of health care generally.

Professor HUYOFF (German Democratic Republic) said that his delegation had noted with concern the critical assessment made of the health manpower situation. The reasons for such an unsatisfactory state of affairs, with over US$ 45 million earmarked for country programmes alone, were not sufficiently explained. His delegation would like to have more information in order to be better able to evaluate the measures taken.

From worldwide observations, it was believed in his country that absolute priority should be given to "on-site" forms of training dealing with the problems encountered on the spot.

Dr QUBEIN (Jordan) said that his delegation approved the proposals in the health manpower development programme for 1986-1987.
His country's new health manpower development plan was designed to provide the primary health workers, who would staff the newly established health centres, and to encourage self-reliance and substitution of national and local staff for foreign health personnel. To that end two new nursing colleges with two midwifery schools and 12 schools for assistant nurses had been established in 1984. The plan also included training and retraining of existing health workers to improve their knowledge, skills and performance and in-service training of physicians in the areas of primary health care and health management; in that connection, two manuals, one on primary health care and the other on health planning, administration and supervision, had been developed and distributed to primary health care physicians; the primary health care manual was also distributed to primary health care nurses and midwives. Under the new plan, the training institutions of the Ministry of Health, the Royal Medical Services and the universities, as well as other nongovernmental training institutions, were actively involved in the training and retraining of health manpower. Finally, the plan provided for equitable distribution of health personnel to all needy areas, and the revision of curricula, the adoption of a credit hours system and the development of job descriptions were under consideration by senior officials of the Ministry of Health in collaboration with the universities. There was also a centre for continuing education in the University of Jordan, which was used to meet the needs of the Ministry of Health.

Mr BENCHEIKH (Morocco) said that his delegation wished to introduce a draft resolution on the maintenance of national health budgets at a level compatible with the achievement of the goal of health for all by the year 2000. It was clear that the economic crisis confronting the developing countries, in particular the least developed among them, and the policies adopted for economic recovery were leading to the restriction of their national health budgets at the primary preventive level, which had adverse effects on socioeconomic development. That point was also dealt with in paragraph 3 of the Director-General's Introduction to the proposed programme budget. It should also be borne in mind that the populations of those countries were increasing by an average of 2% a year, while prices were increasing at an average rate of 10%, and even 100% in some countries; the budgetary constraints resulting from that situation were essentially focused on the social sectors and tended to have the greatest impact on health services. Accordingly, the implementation of health for all by the year 2000 might well remain a dead letter. That was why his delegation, basing itself on earlier World Health Assembly resolutions, was proposing that the Director-General should be requested to make the necessary contacts with Member States and international organizations and agencies with a view to maintaining at present levels the share of national budgets allocated to health services and even increasing it so far as possible. The Director-General should also report to a forthcoming Assembly on the results of measures taken under that resolution.

The CHAIRMAN invited the delegate of Morocco to supply the Secretariat with a copy of his draft resolution, so that it could be made available to members of the Committee for consideration at a later stage.1

Dr WILLIAMS (Sierra Leone) said that her country had no medical school and therefore had to have all its doctors trained in institutions overseas. Where other personnel was concerned, however, efforts were being made to provide training in Sierra Leone, although the authorities relied heavily on the granting of fellowships for the training of all health personnel inside and outside the country. Great reliance was placed on the work of auxiliaries, particularly traditional health practitioners, including traditional birth attendants, in providing primary health care. Noting that the amount provided for that purpose in the proposed budget did not seem to suffice, her delegation wished to appeal to the Director-General to use his good offices to obtain extrabudgetary funds for the extension and improvement of the training of traditional health practitioners and of their instructors. Assistance was also required in the integration of traditional health practitioners in primary health care programmes, since it was now clear that if health programmes were to succeed, they must bring in the traditional health practitioners, who had a considerable influence over the people in all parts of her country.

Dr BROTO WASISTO (Indonesia) said that his country gave high priority to its health manpower development programme. During the preparation of the fourth five-year health plan (1984-1989) it had been found that there was, in Indonesia, a severe shortage of health manpower for the achievement of its health development targets, and a special working group had been set up to develop health manpower planning. The task was not an easy one, in view of the great scarcity of national experts in that field, and Indonesia wished to recruit a group of international experts for three or four years to complete its health manpower plan,

1 See p. 131.
which was reviewed annually and required certain adjustments. Indonesia would be grateful if WHO and other international agencies would carry out more training exercises and would conduct seminars on health manpower development with a view to strengthening national expertise in health manpower planning.

Finally, his delegation fully supported the programme of activities set out in the proposed programme budget.

Dr TARIMO (Director, Division of Strengthening of Health Services), replying to questions raised by the delegate of the USSR in connection with the organization of health systems based on primary health care, agreed with him that the need to present primary health care systems as part of overall national health systems and not as separate entities was a very important issue. Indeed many countries had been faced with serious problems when they had tried to establish or strengthen only peripheral parts of health systems without concurrently ensuring that the other levels of the system were equally developed. The intention had been to bring out that point in paragraph 7 of the statement for programme 4. Further emphasis would be given to it in future.

With regard to the comment that, although problems had been encountered in the development of primary health care, some positive innovations had been made in a number of countries, perhaps undue emphasis had been laid on the negative side of that development in various countries while the fact that the economic situation might not affect all countries equally in the development of primary health care had not been stressed. An attempt would be made to redress the balance in future documents of that kind.

Dr FÜLÖP (Director, Division of Health Manpower Development), replying to the Chinese delegate's suggestion that increasing attention be paid to teacher training, reassured him that the strengthening of health training institutions was to continue (paragraph 27 of the programme statement). Teacher training was a programme element in which WHO had wide experience, having supported the development of national teacher training facilities and programmes over the past 15 years, during which a considerable amount of national experience had been accumulated in most of the interested Member States. A problem that had arisen with regard to the programme was that the original direction in teacher training had been to allow teachers to learn how to do their teaching job better regardless of what they were teaching; the emphasis of the programme had now been shifted to helping teachers to become agents of change in order to foster the reorientation of training programmes towards health for all.

The Chinese delegate had also asked for some clarifications concerning health manpower management, or the promotion of better utilization of trained health personnel; that subject was dealt with in paragraph 24. In paragraph 25, activities relating to continuing education were also listed. He emphasized that health manpower management was a relatively new concern, to which WHO had begun to pay attention only some four or five years previously; since then, however, it had become one of the most important elements of the programme and two interregional consultations on it had been held recently— one in Bangalore (India) 18 months previously, and one in Tashkent (USSR) only a few weeks previously— at which participants had discussed national situations with regard to health manpower management and had prepared recommendations on possible improvements.

In reply to the United Kingdom delegate, who had asked about the Executive Board's recommendations on fellowships, he drew attention to resolution EB71.R6, in paragraph 4 of which the Director-General and Regional Directors were requested to respond favourably to government requests for fellowships only if those requests were in strict conformity with the Organization's policy on fellowships.

The delegate of the German Democratic Republic had drawn attention to the unsatisfactory general situation of health manpower in spite of all the efforts made. There was general agreement in WHO with that evaluation, but he wished to draw attention to paragraph 17 of the programme statement, where it was stated that, although there were still many problems to be faced in improving the national health manpower development process and increasing its relevance, much progress had been made during the past few years.

Finally, with regard to the need to integrate traditional health practitioners in primary health care activities, referred to by the delegate of Sierra Leone, he drew attention to the statement in paragraph 20 that in certain regions national efforts to integrate the policies for traditional health practitioners into health manpower policies would be supported. An interregional meeting on the development of policies for the integration of traditional health practitioners had been held in New Delhi, in February 1985, with the participation of 10 countries, and the intention was to follow up that meeting by promoting the organization of similar workshops in interested countries.

(For continuation, see summary record of the fourth meeting, page 40.)

The meeting rose at 11h20.
FOURTH MEETING
Saturday, 11 May 1985, at 9h00
Chairman: Dr D. G. MAKUTO (Zimbabwe)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1986-1987: Item 22 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II) (continued)

PROGRAMME POLICY MATTERS: Item 22.2 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II, Chapter II) (continued)

Health system infrastructure ( Appropriation Section 2; Documents PB/86-87, pages 71-105; EB75/1985/REC/1, Part II, Chapter II, paragraphs 25-36; and A38/INF.DOC./7) (continued)

Health system development (programme 3) (continued from the third meeting, page 36)

Mrs BOROTHO (Lesotho) said that health situation and trend assessment was by now fully recognized as being the very backbone of overall health system development. It was also a prerequisite for monitoring progress in the implementation of the health-for-all strategy. Her delegation therefore appreciated WHO's intention to strengthen the capacity of countries to carry out that important exercise, but wished to indicate some of the problems facing her own country in that regard.

In the first place, manpower was limited and for the most part over-stretched so that the people involved were unable to apply themselves to what they realized must be done. Their difficulties were compounded by their limited skills. The training of nationals to help them to cope, despite limitations of time, was therefore an urgent need. She stressed that any assistance should focus mainly on developing national expertise rather than providing experts to carry out the exercise, since experts tended to depart without improving the local capabilities that would ensure continuity.

Intersectoral coordination would be improved if there were a closer and more direct involvement of WHO at country level, so as to assist ministries of health in their advocacy of the health-for-all strategy. They could then work in partnership to develop sensitivity to the policies and actions required among a wider multisectoral group, in particular, heads of governments and other policy-makers, as well as major organizations within the country. Continued emphasis on what ministries of health should do was merely preaching to the converted. The need now was to assist ministries of health to convert others - in particular ministries of finance, planning and development, personnel departments - and to involve them in the action needed. They all needed to be made more aware of the health-for-all strategy. The action plans prepared by ministries of health, in cooperation with WHO, were constantly meeting with resistance and lack of cooperation from the above-mentioned ministries and departments; ministries of agriculture, education and rural development, on the other hand, were cooperating. In view of the importance of intersectoral cooperation at national level, her delegation would welcome a draft resolution on the subject.

While there was general recognition that health systems research should form a basic support of health services planning and management, the lack of expertise and skill at implementation levels was a serious drawback. WHO and national efforts should therefore be more definitely directed towards developing those skills at programme implementation level.

Health manpower (programme 5) (continued from the third meeting, page 39)

Professor DAVIES (Israel) referred to the programme activities for health manpower mentioned on page 95 of the proposed programme budget. In his view, for all the programmes which WHO was promoting there existed a basic need for information, which in many countries was lacking. Reference had been made during the debate to the problem of limited manpower. Even with the manpower available, there appeared to be little appreciation of the need for greater effort to be put into measuring the health and attributes of the community rather
than those of individuals treated or cared for by direct contact. His delegation therefore considered that there was a need for the development of learning materials in basic community epidemiology, or scientific methods as applied to community health, so that everyone involved in the health care system would become a partner in the collection of information which would enable programmes to be better directed and evaluated. WHO could play a role in that respect, as could a partnership between countries with the same kinds of problems in developing such learning materials.

In an association of schools of public health that he had the honour to represent elsewhere, it was considered that the training of public health workers needed to be modified so that they could provide teaching in community-oriented scientific methodology to all those working at every level in the community and especially to those engaged in primary health care.

Dr TARIMO (Director, Division of Strengthening of Health Services) responding to the comments made by the delegates of Lesotho and, earlier in the debate, of Sweden, on the importance of intersectoral action for primary health care and the problems involved in achieving it, reassured them that WHO was making efforts to support countries in that area. In the first place, the Committee would recall that the Technical Discussions in 1986 would be on the promotion of intersectoral cooperation for health development, with the aim of promoting interest, better understanding and an exchange of experiences on how to overcome the problems.

Within WHO itself, a working group was not only preparing for those Technical Discussions, but was also mobilizing the various programmes involved or having intersectoral aspects in their action for health development. For example, only two weeks previously a meeting, held at headquarters, had brought together high-level decision-making representatives from different sectors, including a number of ministers in the area of economic planning, and high officials from prime ministers' offices and other sectors. Their deliberations had indicated the extent of the problems involved and, while all agreed on the importance of intersectoral action, they realized that the real problem was how to ensure its implementation. He could therefore assure members of the Committee that those activities were being strengthened and that the suggestions made by the delegates of Sweden and Lesotho would be taken into account in the work of the group. It was hoped, too, that the Technical Discussions would further mobilize interest in the subject.

Dr FULOP (Director, Division of Health Manpower Development), responding to comments on health manpower issues, thanked the delegate of Lesotho for drawing attention to the problems of intersectoral coordination. The fact that, in paragraph 19 of the programme statement the words "intersectoral coordination" were underlined showed that the Organization was fully aware of the importance of the issue. WHO had been actively promoting such coordination over the past 10 years since the adoption, in 1976, of resolution WHA29.72 which throughout requested the Director-General to promote, and Member States to develop, intersectoral coordination in the field of health manpower development. The extreme importance of the problems was fully realized and it was considered that the way to solve then lay in the establishment of intersectoral coordinating mechanisms at country level which would involve all the interested parties - not only ministries of health, but the universities and those concerned with planning and finance, as the delegate of Lesotho had suggested. Although a number of countries already possessed such coordinating mechanisms, much more needed to be done. The way WHO intended to proceed was set out in paragraph 19 of the programme statement.

As regards the comments made by the delegate of Israel on the problem of teaching/learning material, especially in the field of epidemiology at the community level, again, in paragraph 37 of the programme statement, the words "health teaching/learning material" were underlined, thus indicating the importance attached to the subject. That paragraph showed how WHO's programme had developed over the past few years. At present, 10 countries were involved in a network of national centres, eight of them being in the African Region, on the implementation of a programme whereby those countries would become self-sufficient in producing teaching/learning material adapted to their specific local conditions and in their own languages. Teaching/learning material in epidemiology was a priority issue. In addition, WHO was promoting and collaborating with a network of teachers in epidemiology, one of whose main tasks was to develop teaching material and to train teachers both to produce and to use that material.

Public information and education for health (programme 6)

Professor SENAULT (France) welcomed both the recent restructuring of the programme and the increase in the provision for it. His delegation considered that the activities proposed corresponded satisfactorily to the targets to be achieved. Partly, perhaps, as a result of
The Technical Discussions of two years previously, governments were certainly taking public information and education for health more seriously. There was, however, still room for improvement, and the need for coordination at all levels of WHO and Member States, as mentioned in the proposed programme budget, was of particular interest to his delegation.

As far as the European Region was concerned, he could confirm that the Regional Director was endeavouring to avoid competition between health workers and workers in sociology and psychology, and to ensure that they pooled their skills in the information and education fields. It was therefore satisfactory to note that the European Region intended to produce papers on self-help and health and on medical sociology (paragraph 13 of the programme statement).

He noted the intention expressed in paragraph 29 to extend the networks of collaborating research and information centres. That was important, since, where research was concerned, much remained to be done in determining how people themselves would be involved, as was required by any coherent policy for the promotion of health. His government had felt the need for such involvement and had set up health promotion committees in regions, départements and communities which aimed at bringing together as many as possible of the people interested in promoting that activity.

His delegation noted with appreciation the plans to broaden the scope and content of the World Health magazine (paragraph 31) which, like the other health information publications should also be improved as opportunity arose.

The role of nongovernmental organizations in health education and information was important at all levels and he noted with satisfaction that efforts were to be made to establish links with the mass media. The latter, who were currently particularly important purveyors of information, often lacked understanding and used a type of language different from that of policy-makers. An attempt should be made to bring the aims of those responsible for health services and the way they were presented in the mass media more into line.

Dr BRÄMER (German Democratic Republic), noting with satisfaction the reference in paragraph 36 of the Executive Board's report to the importance of the preservation of peace, the achievement of social equity, the right to work and other basic human rights, as prerequisites for healthy life-styles, looked forward to further progress in meeting those requirements.

The substantial increase in allocations to public information and education for health called for a careful evaluation of programme activities. His delegation took the view that WHO should be active mainly in fields where there existed scientifically substantiated methods and a store of knowledge, and therefore, like the delegation of France, particularly supported research activities; it also stressed the growing importance of international high-level exchanges of experience. In coming years his country would be concentrating its activities on health information for the 14 to 25 age group. The annual meetings and seminars to be organized as from 1986 by the WHO collaborating centre at the German Hygiene Museum in his country, on behalf of the Regional Office for Europe, and dealing primarily with the methodology and evaluation of health education might prove useful in that connection.

Dr LIU Xirong (China) expressed his delegation's approval of the Organization's current and proposed programme. In the past two years mutually beneficial cooperation had been established between his country and WHO as a result of which, with the support of the Regional Office for the Western Pacific and the Chinese Ministry of Health, Chinese language versions of articles from World Health magazine were now being published in a Chinese review, entitled Health, which had a circulation of 600,000. The initiative had been warmly welcomed by health workers in his country. That kind of cooperation not only enabled health workers to learn from the experience of others but also developed public understanding of the strategy for health for all by the year 2000 to the satisfaction of all.

He expressed the hope that periodical exchanges of experience would be organized by WHO, and that exchanges of teaching materials would be further developed.

Mr BALAKRISHNAN (India), expressing support for the programme as a whole, wished to see more emphasis on the dissemination of information material in local languages, and full use made of television, which was a fast-growing medium in the developing countries.

Mr LUPTON (United Kingdom of Great Britain and Northern Ireland) said that his delegation welcomed the increasing attention being given by WHO to the whole question of developing interrelationships between the media and the health sector.

It also supported the suggestion made by the Executive Board to the effect that the theme for World Health Day be selected and made known at least twelve months in advance, since that would help countries to develop programmes well in advance so as to give World Health Day the prominence it deserved.
Dr AL-AMADI (Kuwait) said that the programme was very important because the involvement of an enlightened public in the provision of primary health care was essential to the achievement of the goal of health for all by the year 2000. While WHO was to be commended for its public information efforts, through the magazine *World Health* and other publications, the countries themselves did not accord sufficient priority to public information and education for health as a whole. His country had had difficulty, for instance, in obtaining source materials for a television programme on health education.

It was also important for radio and television health information programmes, particularly those which were already available, to be produced and disseminated in local as well as in international languages; that would assist countries wishing to produce their own programmes for the mass media. While WHO could understandably not produce programmes of its own for every part of the world, it could make known where programmes could be obtained. Modern communications, such as satellites, facilitated the dissemination of programmes, and so, of course, the choice of programmes should be made judiciously and with the necessary coordination, bearing in mind their impact on local populations and their compatibility with countries' specific needs.

Professor DAVIES (Israel) expressed his delegation's appreciation of the continued high standard and relevance of the magazine *World Health* and the expanding series of WHO publications, many of which were both trail-blazers in their various fields and authoritative learning materials, thus maintaining WHO's reputation in many parts of the world.

Dr GUZMAN VELIZ (Chile) stressed the importance of the self-care component of primary health care in developing an awareness by the public of its own responsibility for health. While there were publications on self-care, it was not always possible to reproduce them without running into copyright problems and most were intended for professionals. It would be useful if WHO could produce publications on self-care specifically designed for the general public, to whom they could then readily be made available through the media. If people continued to believe that health was solely the responsibility of governments, there would never be sufficient resources to achieve the goal of health for all by the year 2000.

Dr OTOO (Ghana), expressing his appreciation of the programme as a whole, hoped that WHO could prepare and distribute teaching materials specifically for use in schools.

Dr BROTO WASISTO (Indonesia) joined the delegate of the United Kingdom in endorsing the Executive Board's request that Member States be informed of the theme selected for World Health Day one year in advance of the event.

Mr LING (Director, Division of Public Information and Education for Health) was gratified to hear delegates' encouraging comments on the programme. In response to the comment by the delegate of France concerning the integration of public information and education for health, he reminded the Committee that their integration within a single programme was relatively recent, dating from the previous year. The activities were seen as a continuum of communication activities in support of health, ranging from advocacy and the mobilization of political and public support and the support of professional groups to community education work.

He shared the view of several delegates concerning the important role of the media. The media, were, however, to be seen not only as a means of publicizing WHO's work, but also as a partner of WHO and of the health sector, within its responsibility in regard to public health. The media, as a sector, should be involved in the Organization's cross-sectoral work towards the goal of health for all.

Expressing his gratitude for delegates' complimentary comments on the magazine *World Health*, he suggested that the successful formula of cooperation with China whereby WHO material was made available in local languages, might usefully be adopted by other countries, and WHO was prepared to offer assistance, if so requested, for instance in translating such *World Health* material into local languages.

Careful note had been taken of delegates' comments concerning research and exchanges of experience. In regard to the production and distribution of information material, such as television and audiovisual material, due attention was paid to countries' specific cultural patterns and requirements.

In response to the comments made by the delegate of Chile, he said that WHO had convened a meeting on the subject of self-care; a report was available and articles had been published in *World Health* and in the newsletter *Education for Health*. It would not be feasible for the Organization to secure for Member States the many publications that existed on the subject around the world, but it would be prepared to respond to individual requests for information to the extent possible.
In response to the question raised by the delegate of Ghana concerning school health, he informed the Committee that WHO was convening an international consultation on health education for school-age children, both in and out of school, later in 1985, with the participation of UNESCO and UNICEF.

With regard to the request that, in future, Member States be informed earlier of the theme selected for World Health Day, he informed the Committee that the theme for 1986 had been chosen already. It was "Healthy living: everyone a winner", which should allow for a number of activities, including sports. It should be possible for the kit for World Health Day to reach Member States before the end of the year. The theme for 1987 would be "Immunization: the first line of defence".

Health science and technology - health promotion and care (Appropriation Section 3; Documents PB/86-87, pages 106-199; EB75/1985/REC7, Part II, Chapter II, paragraphs 37-56; A38/INF.DOC./3; A38/INF.DOC./4; AND A38/INF.DOC./7)

The CHAIRMAN explained that, since six "major" programmes were included under that heading, he would request the representative of the Executive Board to introduce the views of the Board in two parts.

Dr BORGÒÑO (representative of the Executive Board) said that the manner in which it was proposed to discuss that part of the proposed programme budget would provide the feedback from the Health Assembly which was so important both for the Board and for the Organization. Turning first to the Board's discussion of programme 7 (Research promotion and development), he said that the Board had stressed the need to go beyond the purely medical aspects so as to cover the entire concept of health, including research on primary health care and in such fields as the social sciences, psychology and economics, which were relevant to the goal of health for all by the year 2000. Particular attention should be paid in such research to the factors that determined individual and collective behaviour with regard to health problems. The Board had therefore agreed to recommend that, in order to reflect those broader concerns, the title of the Advisory Committee on Medical Research should be changed to Advisory Committee on Medical and Health Research.

Under programme 8 (General health protection and promotion) the Board had emphasized the need to strengthen or establish policies on nutrition at the country level, where the multisectoral approach was particularly important. Furthermore, the capability of the relevant infrastructure should be reinforced, taking into account the close links between nutrition and primary health care. He referred to the valuable joint WHO/UNICEF activities in that regard in seven countries, which were also of particular importance since they could serve as an entry point in the achievement of the above-mentioned goal. The Board had also stressed the desirability of epidemiological nutritional surveillance which would permit the most rational and comprehensive programme monitoring and evaluation. Consideration had also been given to the growing problem not only in the developed countries, but also in many developing ones, of problems arising from over-eating, including obesity, and its relation to such chronic diseases as cardiovascular diseases and diabetes. With regard to xerophthalmia, substantial progress had been made since the Thirty-seventh World Health Assembly had adopted resolution WHA37.18 on that subject.

In the broad and highly important field of oral health, the Board had drawn attention to the imbalance between prevention and treatment, and to the need to give priority to the former; that was important at the country level and should also be reflected in budgetary allocations. Moreover, there was a growing need for the dental team to be integrated with the primary health care team; that could have far-reaching results. The dental curriculum should also be changed in keeping with the emphasis on prevention.

The Board had stressed the need to adopt a multisectoral approach in relation to accident prevention, among which traffic accidents called for special attention.

On the vast subject of maternal and child health (programme 9.1), feedback from the Health Assembly was extremely important. He drew attention to the integration of maternal and child health with certain specific activities, such as immunization and the control of diarrhoeal and respiratory diseases where children, especially in developing countries, constituted the most vulnerable group. Emphasis had been placed in the programme on the concept of high-risk groups, which might, of course, differ from country to country. Greater attention should also be paid to pregnancy and childbirth which would appear to have received insufficient emphasis hitherto and in which new technology was particularly important. In primary health care, emphasis should be placed on the surveillance of healthy children and on monitoring child growth and development, since that was of the greatest importance from the point of view of health in later life.
With regard to research on human reproduction (programme 9.2), he stressed the extreme importance of the Organization's role in coordination which was beneficial not only from the point of view of technical and administrative objectives of the programme, but also made it possible to obtain increased extrabudgetary funds, thus ensuring that the programme could be appropriately extended. The Board had noted that there had been a decrease in the extrabudgetary funds for such activities as compared with the previous biennium, but was hopeful that the estimated budgetary allocations for the 1986-1987 biennium would be available.

Programme 9.3 (Workers' health) was clearly of great importance. The Organization, the regions and countries should support epidemiological studies aimed at increasing the understanding of the specific problems of workers' health, especially among such groups as agricultural and building workers, miners, and those employed in small undertakings. It was also vital that health service infrastructures specifically for workers should be developed and strengthened in close cooperation with other sectors, thus illustrating once again the relevance of a multisectoral approach to health programmes. In addition, technologies should be developed aimed at providing improved data or applying new methods enabling a substantial improvement to be made in health of that important sector of the population.

Finally, regarding programme 9.4, the problem of the health of the elderly was everywhere of growing concern and was one that affected not only the developed but also developing countries. An accurate epidemiological assessment of the situation, by means of national surveys, was essential, the goal being to add life to years, rather than years to life. Based on that assessment, national policies and programmes should be developed and implemented in keeping with the situation in the different countries. To that end, teaching materials and monographs should be prepared in order to disseminate existing knowledge, with particular emphasis on the concept of self-care, since the active participation of the elderly themselves was necessary. The nongovernmental organizations could clearly make a major contribution in that connection.

Research promotion and development (programme 7)

Dr Sung Woo LEE (Republic of Korea) stated that his delegation fully supported the programme activities for 1986-1987. The Director-General and his staff should be commended for the excellent way in which they had been presented, in particular in respect of research on the socioeconomic and behavioural determinants of health.

In the Republic of Korea, extensive research had been carried out in the field of health services so as to assess the situation throughout the country, and the findings had been widely used as a basis for the reorientation, further development and regionalization of the health services. That approach had also been used to find alternative methods for the further long-term development of national health services. He expressed his thanks to WHO, and particularly to the Regional Director for the Western Pacific, for the assistance provided.

Research promotion and development constituted an essential component of national strategies for the promotion and development of primary health care. His delegation therefore stressed that national capabilities for undertaking health services research were more or less completely lacking in most of the developing countries, especially at a time of economic difficulties, and accordingly strongly urged that more funds should be made available under the programme concerned so as to help Member countries to carry out more research of that type. His delegation also wholeheartedly endorsed the suggestion made by the Executive Board, at its seventy-fifth session, that the Director-General consider making an adjustment in the area of research by means of his development programme.

Dr BANKOWSKI (Council for International Organizations of Medical Sciences), speaking at the invitation of the Chairman, referred to the long tradition of collaboration between the Council for International Organizations of Medical Sciences (CIOMS) and WHO. He recalled the particular interest of CIOMS in biomedical research, especially bioethics, which had led to the elaboration of ethical guidelines and principles.

Following animated discussions, the Health Assembly had, at its previous session, adopted resolution WHA37.13 on the spiritual dimension of the Global Strategy for Health for All. That was a complicated subject, but the confusion existing in that regard was very often due to misunderstandings rather than disagreements. In an attempt to clarify those issues, CIOMS had recently initiated a study on the role of ethics and human values in health policy decision-making.

Many health policy decisions raised ethical questions, such as who should receive health services, how resources should be allocated and when health care should be begun or ended. Furthermore, ethical values differed substantially from country to country, arising out of
differences in cultural, religious and historical traditions, and their interaction with health policy-making therefore varied from country to country; political, economic or other issues could also have an effect. CIOMS had initiated an international collaborative programme to explore that interaction, beginning with an international conference in Athens in November 1984 on "Health Policy - Ethics and Human Values" which had given rise to an international dialogue on those issues. Highlights of the conference were available to the Health Assembly, and the full proceedings would be ready in a month's time.

The conference, which had brought together health policy-makers, health professionals and philosophers, etc., from 40 countries representing varying cultures and traditions, had been a striking success. It had identified important issues and established common grounds for further collaborative exploration, as well as making it possible for health policy makers, health-care professionals, and those concerned with ethical issues to begin to appreciate their interdependence. It had been felt that some mechanism should be established to support a continued inquiry into issues of regional interest, with CIOMS serving as a the organizing focal point for that International Collaborative Programme on Ethics and Human Values in relation to Health Policy.

A thematic framework for that programme would be WHO's goal of health for all, which raised many questions with strong implications for health policy, ethics and human values. Whereas WHO and other concerned bodies were experienced in dealing with technical, political, economic and managerial problems associated with health for all, the issues relating to human values were addressed less often and less well; indeed, it would seem that value conflicts were not recognized as such and often found expression in the form of technical, political or managerial obstacles.

He expressed the gratitude of CIOMS to WHO for the collaboration and help extended by its Secretariat, both at headquarters and in the regions, as well as by the global and regional Advisory Committees on Medical Research. He assured the Health Assembly of CIOMS' readiness to continue and strengthen its collaboration with WHO on all subjects of mutual interest.

Dr MALONE (United States of America) said that the Director-General's well-articulated plan for research promotion and development showed that although many research activities had been centred on individual programmes and had been decentralized to the regions, there nevertheless remained a strong and significant role for the research promotion and development programme at headquarters. The analysis provided clear justification of that situation and implied two opposing but interdependent imperatives, namely that, on the one hand, most developing countries had inadequate capacities for carrying out biomedical and health service research, while on the other hand an explosion was taking place in knowledge about life processes and disease and an abundance of complex instruments were being developed for diagnosing, preventing and treating those conditions, primarily in the industrialized countries.

The United States delegation appreciated the difficulty of WHO's task of bridging the gap through the transfer of knowledge and techniques to improve health in developing countries and to reduce the disease rates referred to in subsequent sections of the proposed programme budget. It would be interesting to learn how the Secretariat intended to accomplish the awesome task of research promotion, coordination and transfer of knowledge in the face of competing resources and programmes. It was encouraging to see that the global Advisory Committee on Medical Research (ACMR) was reviewing its role and function and it would be interesting to hear about the plans so far developed for the application of appropriate technology.

His delegation firmly believed that the developed nations should expand their cooperation with the less developed countries and the WHO Office of Research Promotion and Development. It noted with satisfaction the increasing number of institutions which WHO had designated as collaborating centres - clearly an important ancillary means of promoting research and the transfer of knowledge. Such collaborative activities had escalated in United States institutions, including its National Institutes of Health, the Centers for Disease Control, other governmental and nongovernmental agencies and universities; for example, there were now 16 WHO collaborating centres involving 13 different research institutes at the National Institutes of Health and another 31 at the Centers for Disease Control, and there were altogether more than 70 such collaborating centres in the United States. During the past year, the United States had also provided several hundred experts and temporary advisers for WHO headquarters and regional meetings and working groups throughout the world. Such efforts should be encouraged by all Member States as a means of helping the Office of Research Promotion and Development to shoulder its responsibilities and achieve its objectives. He asked what impact such institutional collaboration was having on research and training activities.
His delegation fully concurred with the objective of developing research training grants and “visiting scientist” grants in 1986-1987. Sufficient and appropriate manpower was absolutely essential if the global and national health-for-all strategies were to be realized. He asked for more information on how those training grants would be evaluated and awarded and about the plans being made to ensure the placement and retention of trained staff within the health care structure of Member States.

Finally, the United States delegation was glad to see that increased emphasis would be placed on research into the socioeconomic and behavioural determinants of health; it believed that the proposed analyses would lead to improved health through channels which would be effective even where research capabilities and complex health care systems had not yet been fully developed.

Dr SAVEL'EV (Union of Soviet Socialist Republics) said that his delegation could support the measures proposed in programme 7 and was particularly interested in the proposed study of interrelationships between the health level of the population and various socioeconomic factors. The increased allocation for that important programme, in real terms, was also welcome.

Nevertheless, the programme could not be considered in isolation from the summary table on research activities set out under Global and interregional activities in Annex 3 (pages 427-429) of the proposed programme budget. Although the reappearance of that table in the document after its absence since 1982 could only be welcomed, the data it contained unfortunately showed that the proposed overall allocation for research activities in the regular budget in 1986-1987 had been reduced by the substantial sum of US$ 334 000 in comparison with 1984-1985. Sound scientific bases had always been the gate of the success of WHO activities and of their increased efficiency; any relaxation of the Organization’s efforts in that regard was likely to have serious repercussions on the implementation of health-for-all strategies. The USSR therefore welcomed the Executive Board’s recommendation that additional funds be allocated to research activities from the Director-General’s Development Programme.

Close attention should now be paid to the relation between research and practical health care and to improving methods of applying the results of research in practice. That problem deserved to be discussed in the global ACMR and at sessions of the regional committees, the Executive Board and the World Health Assembly.

Dr AL-AWADI (Kuwait) said that, although research must naturally be carried out at the laboratories, centres and institutes referred to by previous speakers, it was vitally important to adapt it for practical application to health services as quickly as possible. WHO was responsible to the peoples of the world for achieving the target of health for all by the year 2000, and in order to succeed it must begin by simplifying research methods and disseminating the results in such a way that research at institutions and through fellowships should be regarded primarily as means of providing health services. In order to promote the concept of simplified and applied research, he proposed that WHO should consider awarding prizes to research workers in the field of primary health care, leaving awards for achievement in specialized areas to the developed countries. The stress thus laid on the true role of health research workers would have a number of advantages, including encouragement for primary health care and other field workers, inciting researchers from universities and institutes to go out into the field and stimulating the practical research without which the target of health for all by the year 2000 could not be achieved.

Turning to programme 9.4 (Health of the elderly), he said that the question was of concern to all developing countries because of the changes taking place in traditional family structures. Those countries must try to avoid following the example of industrialized States, where families were so often dispersed and attempts were made to solve the health problems of each artificial category in isolation. Such an approach was fundamentally inhuman, since the physical segregation of elderly people in specialized institutions was usually damaging to their mental stability; the developing countries must be warned against encouraging the dissolution of family structures. At the latest meeting of CIOMS, consideration had been given to the question of human values in the application of health services: WHO must stress the importance of the spiritual dimension and of ethical standards in all aspects of health care.

Mr BALAKRISHNAN (India) said that his delegation generally supported programmes 7, 8 and 9.

Programme 7 (Research promotion and development) was extremely important for the developing countries; the results of research already carried out should be disseminated effectively to those countries and should be applied appropriately in the optimal manner;
the correct balance should be struck between priorities for basic research, applied research and institution-strengthening activities, and access to technology should be provided on reasonable terms.

The situation analysis in paragraphs 5 and 6 of the programme statement indicated the extremely difficult resource position of the developing countries in that sector. Unless those countries could return to the path of economic growth, resource constraints would persist in the area of research as well as in other key components of the health-for-all strategy. In that connection, his delegation was co-sponsor of a draft resolution on the impact of the world economic situation on the achievement of health for all by the year 2000.

Another important aspect of the research promotion and development programme was the role of intercountry exchange of information and cooperation among institutions and centres in different countries. A prime example was technical cooperation among developing countries (TCDC), which was a potential means of speeding up progress towards the goal of health for all by the year 2000. The Indian delegation was co-sponsor of a draft resolution in support of the goal of health for all, which called for concentration on the further development of economic and technical cooperation among developing countries.

Where programme 8 (General health protection and promotion) was concerned, the key role of intersectoral collaboration and community involvement needed to be fully appreciated. In connection with programme 9 (Protection and promotion of the health of specific population groups) the Indian delegation was somewhat concerned by the hostile climate that seemed to be developing in some donor countries towards certain elements of the human reproduction research programme; it also wished to stress the need for more applied research.

Professor BA (Senegal) welcomed the interest shown in programme 7 which reflected the new trend of decentralization of the activities proposed. Research was a process that embodied a number of different stages. The first stage, the identification of problems and the choice of subjects for research, was relatively easy compared with subsequent stages. The second stage comprised the preparation and development of coherent, relevant and feasible research projects, a process that required skill and mastery of the subject. The third stage, the implementation of projects, also obviously required skill and expertise for effective realization. The final stage, the processing and utilization of research results, was unfortunately frequently not carried out properly. Considerable support was needed for those various elements of research and it was important to undertake training in research methodology. It was equally important to pay attention to the motivation of research workers.

Dr KYELEM (Burkina Faso) joined previous speakers in commending the work of the Executive Board in the area under consideration. His delegation fully supported the budget proposals for programme 7. He noted, in particular, the statement made in paragraph 14 of the programme statement regarding the need to strengthen the multinational collaborative network in order to stimulate collaboration between research workers and the transfer and dissemination of scientific knowledge within the framework of collaboration between developed and developing countries and TCDC. The knowledge already available would permit more effective action if it were sufficiently widely disseminated and properly used.

Dr OLDFIELD (Gambia) joined other speakers in strongly endorsing programme 7. Biomedical research had continued to contribute positively to health technology. For many Member States, the main preoccupation was the application of scientific knowledge. He therefore noted with satisfaction the emphasis given to health systems research - the Executive Board had given its support to that area and some speakers had recommended that funds from the Director-General’s Development Programme be allocated to it. As Member States progressed in the implementation of health strategies, research for planning and management would become increasingly important. WHO support at the country level would be required to strengthen national capabilities. The developing countries were experiencing difficulties in the fields of behavioural and socioeconomic research, and he was pleased to note the emphasis given to those aspects in the budget proposals.

Dr QUBEIN (Jordan) agreed that attention should be given to simple methods of research in primary health care and that research should encompass all dimensions within the concept of health. Mechanisms to permit the follow up of epidemiological research were needed if national means of combating diseases were to be found. The Ministry of Health in Jordan had

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1 For text, see p. 128.
2 For text, see p. 129.
a special research department, although it was not working at full capacity as greater support was needed. WHO had provided assistance for two studies - one on primary health care services and one on the development of health manpower. The Government was collaborating with Jordan's two universities in research and research development activities. Such research should take account of the prevailing conditions if solutions were to be found. For example, in Jordan the problems concerning poliomyelitis and neonatal tetanus had been defined. Action to combat poliomyelitis was under way and the implementation of measures against neonatal tetanus was beginning.

Dr KLIVAROVA (Czechoslovakia) expressed her delegation's support for programme 7. Her country would be interested to participate in the activities proposed. She supported the Regional Director for Europe in his views on the name of the regional ACMR. Czechoslovakia was hoping to be able to send a member to the regional ACMR again in the near future in the normal course of rotating membership.

Scientific research in Czechoslovakia was concentrated on the most important aspects of medical activities and health and was coordinated through a Government plan which incorporated research carried out under the aegis of the Ministries of Health and National Education and the Academies of Sciences. The Ministries of Health in turn collaborated with national medical and clinical institutions in many research programmes. Thus it was possible to direct financial resources to the areas where they were most needed.

Dr TIDJANI (Togo) commended the Executive Board on its work in the consideration of research promotion and development programme and supported its view of the importance of research, which was indeed essential if the medical sciences were to progress for the benefit of populations. Before research was undertaken, priorities should be set taking due account of the social and cultural realities prevailing in countries. Seminars and workshops should be increased to make maximum use of those competent in research. Greater emphasis should be given in the future to the processing and utilization of the results of medical research and to wider dissemination for the benefit of all countries.

Mr HOSSAIN (Bangladesh) asked for his delegation to be added to the list of co-sponsors of the draft resolution on TCDC in support of the goal of health for all.1 Bangladesh had consistently supported the principles of TCDC and was one of the few developing countries to offer places in its medical colleges and institutions to persons from other countries. Places had been offered to students from Bhutan, Islamic Republic of Iran, Nepal, Nigeria, the Palestine Liberation Organization and others. The International Centre for Diarrhoeal Disease Research, Bangladesh, was collaborating in various aspects of diarrhoeal disease research. Bangladesh was active also in regional cooperation, collaborating for example in the promotion of socioeconomic development in the Member countries, including the implementation of health-for-all strategies.

Dr BORGÓNO  (representative of the Executive Board) recalled that in January 1984 the Executive Board had discussed a report from the Chairman of the global ACMR. Considerable attention had been given to the reorientation of the work of that Committee so that while scientific research was maintained, research in primary health care, socioeconomic aspects and health systems infrastructure would be expanded. In January 1985, the Executive Board had suggested that more funds be allocated to programme 3.3 (Health systems research) rather than to programme 7, even though great efforts were being made to obtain extrabudgetary funding in that area. Expansion in that direction was of the utmost importance.

The DEPUTY DIRECTOR-GENERAL recalled that in successive years delegates had made many statements and suggestions expressing their sincere concern regarding research. Unfortunately there was still a considerable difference between what was said at the Health Assembly and what was practised or achieved at the country level. It was still very rare to find a ministry of health that had its own department or unit specifically devoted to research. The delegate of Jordan had mentioned a research unit within Jordan's Ministry of Health but had immediately added that it did not function fully. Most ministries of health, especially in the developing countries, left research - which was vital if the goal of health for all by the year 2000 was to be attained - to universities and research institutes. They should at least generate research in the fields of sociology, epidemiology and the monitoring of changing profiles of health and disease in their own countries in order to modify as appropriate their strategies for the delivery of health care. With some exceptions, few countries boasted respectable national research policies. Member States should take up the challenge to develop such policies as soon as possible.

1 For text, see p. 129.
Research did not necessarily need sophisticated technology, such as nuclear magnetic resonance and ultrasound scanners, or elaborate structures and laboratories. As some delegates had mentioned, observational research, monitoring and research into traditional medicine were all possible by relatively simple means (or as some delegates had called it, "simple research"). Looking back at the history of medical research, there were many examples of breakthroughs being made by clinicians and others using simple mechanisms, for example the discovery that foxglove contained digitalis.

The delegate of the United States of America had raised a number of critical questions. Over the past 15 years, WHO had had the sense, and one might say had been forced, to mobilize the best brains in the best research institutions throughout the world. The benefits of those efforts were beginning to be felt. One had only to read the documents on tropical diseases, malaria and other parasitic diseases, vector biology, etc. to see that many breakthroughs were in sight, for example vaccines for malaria and leprosy.

The transfer of knowledge and coordination was undertaken through many mechanisms. In the United States alone there were over 70 WHO collaborating centres providing the capacity and resources to act on behalf of other Member States. The National Institutes of Health in Bethesda, MD, were one of the major suppliers of expertise and other forms of help. There were also many other WHO collaborating centres in Europe and other regions, undertaking research into numerous specific areas. Their work was having a tremendous impact.

Mention had also been made of training grants, another area that required constant review. Today, far more stringent criteria were used in awarding such grants, enabling people with genuine ability and motivation to take up research. Special mention had been made of research into the economic and behavioural sciences, both of which were crucial and relevant to the Organization's work. In many countries, the social and economic research institutes were not properly or fully utilized from WHO's point of view in the field of medical and health sciences, and the Organization would like to see both developed and developing countries placing greater emphasis on those subjects, particularly bearing in mind how much easier it was to mount intensive preventive and educational campaigns than to set up gigantic institutes for clinical work. At the present time, far more money was going into the treatment of the terminally ill than into preventive and primary health care.

The delegate of Senegal had referred to the subject of motivation. Particularly in the developing countries, nobody dared go into research unless it was backed by funds, career prospects and other support, whereas research careers in the developed countries were given a good deal of prominence and security. In the developing countries, therefore, although the motivation might exist, government policy and attitudes towards research were such that the career was not pursued with sufficient seriousness to achieve tangible results.

Dr ABDELMOUMENE (Office of Research Promotion and Development), replying to the more specific questions raised by delegates, said that there appeared to be particular concern about the widening gap between the developing and the developed countries in the field of research, between the accumulation of technical knowledge, e.g. progress in biotechnology, and its application in the health development of the developing countries. In that connection, a subcommittee of the global ACMR had been set up to deal primarily with the preparation of a general conceptual framework for a research strategy at world level, which would have regional implications. That subcommittee had been very active and had already produced a document that was being discussed by the regional ACMRs. The Organization in fact made increasing use of the subcommittee mechanism to develop programme activities and to cope with the different tasks assigned to the Office of Research Promotion and Development. Three other subcommittees were also in operation: the subcommittee on health manpower research, aimed particularly at the developing countries, another which had been dealing for some years with research on health systems, and yet another set up in 1983 to deal with the problems of the transfer of health technology in the developing countries. The last mentioned had tried to identify recent scientific developments and modern scientific concepts that would have a particular impact on health development and the objective of health for all by the year 2000. It was now engaged in producing a document proposing mechanisms and means of transferring the appropriate technology so that the developing countries could attain the objective of health for all by the year 2000.

A question had been raised on international collaboration and its impact. The Deputy Director-General had already referred to the collaborating centres, and other mechanisms. The Office of Research Promotion and Development was only involved in the administration of the activity developed by the centres and not in the technical aspects of that activity. Of particular relevance was the work being done by the Office in collaboration with the Fogarty International Center (National Institutes of Health, USA) and under the aegis of the Regional Office for the Americas, in the field of assessing the role of international collaboration. That work had been undertaken by the Fogarty International Center in Bethesda, and case
studies were expected to provide certain general conclusions that would establish a methodology and give some indication of the impact of such international collaboration on the level of training of the many fellows passing through those institutes and institutes in other developed countries, and on training in research. That subject led to another specific and important question that had been raised, concerning the entire sector of research training grants and visiting scientists. In that area, too, the Office of Research Promotion and Development only had the task of providing some degree of centralized administration at headquarters. The various technical programmes that funded research training grants followed very strict mechanisms, and the majority of grants involved principally the Special Programme for Research and Training in Tropical Diseases, and the Special Programme of Research, Development and Research Training in Human Reproduction. Other programmes, such as the Diarrhoeal Diseases Control Programme also used headquarters. and level studies were expected working and policy levels. 

Complement what Dr FAO and WHO collaborated regularly for training grants involved principally the Special Programme for Research and Training in Tropical Diseases, and the Special Programme of Research, Development and Research Training in Human Reproduction. Other programmes, such as the Diarrhoeal Diseases Control Programme also used headquarters. and level studies were expected working and policy levels.

The response to the concern repeatedly expressed by the Assembly and the Executive Board, about the brain drain from Third World countries, particularly in relation to the problem of a research career structure. In recent years a number of studies had been made by consultants in the regions involved - Latin America, Africa and Asia - and a meeting on 28 to 31 May would try to consolidate the work done, draw conclusions, and submit recommendations to the Executive Board, and subsequently to the Assembly, aimed at providing clear guidelines at the country level. It was hoped that the meeting would propose specific methods of collaboration and support for countries wishing to consider and implement a career structure development policy within the framework of a general research policy at national level.

Dr Borgofno had already given the necessary clarifications on the budget. However, as far as structuring was concerned, there was a relative decrease which was really a matter of presentation - as, for example, in the budget for the European Region, which in fact might appear to show an increase rather than a decrease. The particular reduction also referred to concerned a specific extrabudgetary subvention relating to the work of a particular collaborating centre.

General health protection and promotion (programme 8)

Mr VIGNAUD (Food and Agriculture Organization of the United Nations) said that the Director-General in his Introduction to the proposed programme budget, had stressed the need for those responsible for the government of their countries to give first priority to the problems of human development; all too often economic problems monopolized attention. The Director-General was in fact saying that man's living conditions could not be determined merely by virtue of calculation of per capita income, but reflected his level of social development. The promotion of a sustained improvement in man's living conditions and quality of life should be the daily concern of governments and international organizations. It was no doubt on the basis of that conviction that WHO had proposed a strategy for health for all. In social development - the basic and indispensable premise of the strategy for health for all - nutrition, and food in a more general sense, were of prime importance. In other words, there was an interrelationship and interdependence between nutrition, food and health. It was natural, therefore, that FAO, concerned mainly with the problems of agriculture and food, should wish to take the floor during the discussion of the activities proposed in the nutrition programme.

Malnutrition was still one of the tragic paradoxes of our time, notwithstanding man's high degree of economic and technological development and the high standard of living of the more developed countries. FAO's statistics showed that in the 1970s the estimated number of undernourished people was some 435 million. That figure had since worsened as a result of the crisis in Africa and the increasing economic problems in many developing countries. It was therefore disheartening to attend discussions in international forums on the prevention of market imbalances due to agricultural surpluses, on the one hand, and on suffering due to lack of food on the other. The strategy for health for all reflected those contradictions and was linked to the concept of food security which had been developed by FAO and endorsed by its Member governments. The final aim of food security was to ensure for all people and at all times access to the staple foods necessary for a calorie intake sufficient to avoid health problems arising from malnutrition or undernourishment. In that context, and following Dr Borgofno's introductory comments, the strengthening of national food policies was one of the main aspects of FAO's concept of food security. FAO was therefore proud to note that there was particularly close collaboration between WHO and FAO regarding food and nutrition, and that there was constant dialogue between the two organizations at technical, working and policy levels.

FAO and WHO collaborated regularly in the fields of nutritional requirements and food standards and safety and in action programmes. Joint activities in relation to nutritional requirements included the FAO/WHO expert committees on energy and protein requirements, and
on requirements of vitamin A, iron, folate and vitamin B12, and planned consultation on the practical application for energy and protein requirements in 1986. Regarding food standards and safety there was FAO/WHO collaboration on a regular basis in the Codex Alimentarius Commission, and expert consultations on pesticide residues and food additives, food irradiation, food safety, the food contaminant monitoring programme, and veterinary drug residues in food.

FAO and WHO were collaborating in the ten-year action plan against vitamin A deficiency. FAO’s activity included the promotion of production of vitamin A and carotene-rich foods at national and household level, promotion of consumption of vitamin A-rich food through nutrition education, and analysis and compilation of data concerning vitamin A consumption and related food habits. FAO and WHO were also collaborating in the evaluation of the activities of the Codex Alimentarius Commission in 1985-1986 with a view to strengthening and streamlining its activities in Africa.

With regard to the FAO/PAHO regional strategy and plan of action for food safety and control for the Caribbean countries, FAO supported community nutrition programmes for Member countries of the Caribbean Food and Nutrition Institute involving the introduction of nutrition in agricultural training, and the development of resource materials. FAO collaborated with the Institute of Nutrition of Central America and Panama in the translation and adaptation of training documents and the introduction of nutrition in agricultural training curricula.

The delegate of the United States of America had suggested, in plenary session, the setting up of a health early warning system, which would undoubtedly require closer technical cooperation between WHO and FAO. An early warning system regarding food shortages had been in operation in FAO since 1975 with the participation of almost 100 countries. By keeping developments in the food situation and the outlook under constant surveillance, the system had proved itself on many occasions to be an essential link in the world’s food security network. In fact, FAO had given the first warning about the African crisis early in 1983. Looking to the future, the system would need to extend, intensify and modify its operations in order to adapt to the rapidly changing state of the world’s food economy. National and regional early warning systems, too, needed to be improved. In that way, the FAO Global Information and Early Warning System would be able to continue to transmit the timely and objective information necessary for food policy-makers and operational relief agencies. By providing that information to food deficit and donor countries alike, the system demonstrated the complementarity of interests that existed in striving toward the goal of food security in today’s interdependent world. It was to be hoped that that would constitute another area of cooperation with WHO.

Dr CORNAZ (Switzerland) said the crucial role of nutrition in health protection and promotion could not be over-emphasized, and she was pleased to note that the budget showed a substantial increase in the resources allocated to it for activities at country level. She also welcomed the links established with primary health care; such links were essential, and were in line with the conclusions of the International Conference on Primary Health Care, Alma-Ata (USSR). There was no doubt that WHO had a role to play in this connection in laying down guidelines for countries to help them decide what action to take, and how to take it. WHO could not fulfill that function solely at international level, but should also play a role at regional level, directly assisting those countries in which socioeconomic and cultural factors were too different for the application of general rules alone to be sufficient.

Regarding young child nutrition, no mention was made in the programme statement on nutrition of the question of weaning; she found that surprising, in view of its importance for the health of the child. WHO should be encouraged to keep that question very much in mind in its nutrition programme as well as in its maternal and child health programme, both in regard to operational research and in regard to programme support.

In paragraph 7 of that same programme statement mention was made of operational research, notably in regard to the diet of women of child bearing age; research was still needed in order to define the nutritional requirements of mothers and children. It was important to be aware of the actual nutritional status of the mother and child, in order to be able to assess their real needs. WHO should help to develop methods which would enable national authorities to appreciate the needs of different population groups - especially disadvantaged groups - at country level. It should also devise ways of helping national authorities to decide what action should be taken by the health services to help meet those needs.

Finally, the monitoring of the growth of young children - which was relevant to both the nutrition and the maternal and child health programmes - were rightly given great emphasis by WHO and UNICEF. However, such monitoring, by the use of growth charts or any other method, would be useless, and even wasteful of resources, unless it led to action wherever growth
Insufficiencies were found. Such action should be both on a general basis, aimed at remedying generalized inadequacies, and on an individual basis, aimed at solving the problem of the individual child who was or was in danger of becoming undernourished. She urged that WHO ensure that growth charts were not used simply as record keeping instruments, but would lead to concrete action, since the promotion of action was the Organization's true role.

Professor SAGHER (Libyan Arab Jamahiriya) recalled that at the Thirty-seventh World Health Assembly his country had co-sponsored a draft resolution relating to the prevention and control of vitamin A deficiency and xerophthalmia. It was now one year since that resolution WHA37.18 had been adopted and, in view of its importance to the health of many of the peoples of the world, he would like to ask what practical steps had been taken to implement it. He requested that a meeting be convened to discuss the progress made by WHO in implementing the resolution. It was to be hoped that delegates of the countries which had co-sponsored the resolution would be able to attend that meeting, along with any other delegates who were interested; the co-sponsoring delegations had been those of: Bahrain, Belgium, Bhutan, Democratic Yemen, the German Democratic Republic, Jordan, Malta, Mauritius, Morocco, New Zealand, Qatar, Somalia, Spain, the Syrian Arab Republic, and Zaire.

Dr MALONE (United States of America) said his delegation was in general well satisfied with the provisions made under "General health protection and promotion". He was glad to note that there was a fuller presentation of issues related to nutrition than there had been in previous years. The oral health programme had made good progress, and his only question was whether methods such as the use of dental sealants had been considered for protection against dental caries during childhood. The activities planned under the accident prevention programme were extremely ambitious, and he was pleased to note that the initial emphasis on road traffic accidents had been broadened to include all common accident risks, with high priority accorded to children, young people and the elderly.

Dr WESTERHOLM (Sweden) said that accidents were still a major threat to health in Sweden; they constituted the chief cause of death among children and young people, and domestic accidents among the elderly were on the increase. Effective accident prevention would thus have a significant effect on the health of the population as a whole, and her Government was currently developing an action programme to combat accidents which was based in part on a new epidemiological approach, featuring an in-depth analysis of the causes of accidents. Key factors in the implementation of that programme were community involvement and the participation of nongovernmental organizations.

Her delegation would welcome increased collaboration with WHO in developing its action programme.

Dr SULAIMAN (Nigeria) fully endorsed the programmes presented under "General health protection and promotion". However, he regretted that at country level there was often a dire lack of adequate programme formulation, notably in such areas as management, intersectoral cooperation, community involvement, involvement of nongovernmental organizations, and monitoring and evaluation. In many of the programmes for health promotion and care, such as nutrition, family health, family planning, basic sanitation, and the Expanded Programme on Immunization, UNICEF and other international agencies had taken the lead, and WHO was being pushed into a peripheral position. The reason for that trend was WHO's lack of flexibility at the country level, and the fact that the decentralization of its activities seemed to have stopped at regional level. Unless WHO programme coordinators and national programme coordinators were empowered to take the initiative at country level and to respond to the programme needs of Member States, as was the case with UNICEF, health for all leadership might pass out of the hands of WHO. He therefore urged that WHO should lay greater emphasis on programme formulation, so that each country would have a clearly defined programme of action to follow in the areas under discussion. The role of the WHO programme coordinator and national programme coordinator should be clearly defined, and sufficient authority should be transferred to them under the decentralization process to enable them to respond promptly to Member States' needs. He considered that the term "Accident prevention" was inappropriate as a title for a programme, since it implied that accidents were a fact of life which had to be accepted. WHO should rather be undertaking a study of negligence as a cause of accidents, and finding ways of preventing negligence through education and other methods. He noted that the budgetary allocation to the programme was dwindling, and hoped that that did not imply any downgrading of its importance.

The meeting rose at 12h45.
PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1986-1987: Item 22 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II) (continued)

PROGRAMME POLICY MATTERS: Item 22.2 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II, Chapter II) (continued)

Health science and technology - health promotion and care (Appropriation Section 3; Documents PB/86-87, pages 106-199; EB75/1985/REC/1, Part II, Chapter II, paragraphs 37-56; A38/INF.DOC./3; A38/INF.DOC./4; and A38/INF.DOC./7) (continued)

General health protection and promotion (programme 8) (continued)

Professor DAVIES (Israel) said that he was gratified to note the modest increase in the regular budget for nutrition (programme 8.1), although it was regrettable that extrabudgetary funds had dropped considerably, which would mean a reduction in the total activity in that field in real terms.

The subjects he wished to raise - oral health and oedema in infancy - were related to a number of different programmes besides those now under discussion, but it was difficult always to keep strictly within programme boundaries. Although oral health might not contribute to mortality, it did, especially in the elderly, contribute greatly to morbidity and malnutrition, and could affect the mental health of those ashamed of being edentulous, particularly women. Surveys in Jerusalem had shown that three-quarters of the elderly population were in urgent need of oral care, and similar studies in many countries had shown oral health to be one of the main problems of older people. He would be glad to hear of any initiative planned by the Organization to meet the challenge of the oral health of the elderly.

Oedema in infancy was linked to failure to breast-feed, and to the use of breast-milk substitutes lacking in iron in a form assimilable by the infant. That was a problem for all countries, both rich and poor, even where the national level of nutrition seemed adequate. It had been shown that iron-deficiency anaemia was a real problem in non-breastfed infants, and there was evidence that the mental and motor development of such infants was retarded. Anaemia in the first year of life might prevent a person from reaching his or her full potential, and illustrated a worldwide problem in which research and practice went hand in hand. His delegation therefore supported the programme of maternal and child health in general, and particularly activities designed to promote breast-feeding and to discover adequate substitutes for breast-milk.

Dr BROTO WASTISO (Indonesia) said that in general he supported the activities listed under nutrition (programme 8.1), particularly the strengthening of national nutrition policies. To that end, as indicated by the Executive Board in paragraph 38 of its report on the programme budget, the scope of the programme should be broadened to combat food shortage and to deal with new elements of malnutrition including certain aspects of the "fast-food" industry. He would welcome a closer collaboration with FAO to ensure a concerted global policy on food and nutrition.

Dr SAVEL'EV (Union of Soviet Socialist Republics) said that the programmes on nutrition and accident prevention (programme 8.3) were well balanced and he commended the very concrete manner in which the current situation was described under oral health (programme 8.2), in which the tasks planned for the next two years were clearly outlined; he was glad that great attention had been paid in that programme to intergovernmental activities, in particular to the work of the demonstration, training and research centres. He endorsed the recommendation that fuller use should be made of goal-oriented methods of management, and of the evaluation of the activities of national stomatological services, by means of microcomputer methods, and
also welcomed the intention to continue research for the evaluation of the effectiveness of new methods of prophylaxis and therapy. He also supported the development of research on periodontal disease.

Dr REZAI (Islamic Republic of Iran) said that while undernutrition was still a major cause of child mortality in some developing countries, unbalanced diet or excessive eating had become a major problem in some developed countries. As long as inequitable distribution of food supplies continued, those problems would remain unsolved.

Existing food resources were known to be adequate for the needs of all peoples of the world, provided that they were properly distributed. How could a country faced with severe malnutrition problems, resulting from hunger due to inadequate food supplies, be expected to provide appropriate programmes for nutrition promotion?

Dr BISHT (India) said that India's chief problem with nutrition was the enormous size of the population that had to be covered by the programmes, including annually 22 million children and a similar number of pregnant women. However, the Government was trying gradually to increase its coverage, supplying vitamin A, iron and folic acid to all mothers and pregnant women, and hoped by 1990 to be able to reach the entire target population.

It had been found that no state in India was free from iodine deficiency diseases, and a decision had been taken at national level to iodize salt. Iron deficiency anaemia was another large-scale problem in India, and fortification of salt with iron was being investigated; but, further research was needed to establish that it would not interfere with iodization.

The International Code of Marketing of Breast-milk Substitutes should be strengthened in order to encourage breast-feeding, particularly among the urban educated.

India was ensuring that all the needs of pregnant women and of children in regard to nutrition and immunization would be met by the end of the decade. He stressed that it was essential to take a holistic approach in applying health programmes if the goal of health for all was to be achieved.

Dr NAKATANI (Japan) said that in Japan the aging of the population was rapidly increasing; life-expectancy was now 80 years for women and 75 years for men. There was growing interest in nutrition as a means of controlling many chronic diseases, including hypertension, diabetes and cancer.

There was not yet sufficient knowledge of the relationship between nutrition and illness, compared with that in other biomedical fields. However, it was known that there was a close link between high salt intake and hypertension, with its attendant risk of cerebrovascular accidents. A nationwide campaign to reduce salt intake had been launched, which had succeeded in reducing both mortality and morbidity from cerebrovascular disease, and life-style guidelines as a means of controlling other types of chronic illness were being developed. He hoped that WHO would continue to strengthen its activities in health protection and promotion with emphasis on nutrition.

Dr QUBEIN (Jordan) said Jordan attached great importance to food quality control, and both imported and locally-produced food products were subjected to careful chemical analysis before being marketed, to ensure that they were fit for human consumption in accordance with the FAO/WHO guidelines in the Codex alimentarius. Special importance was attached to the shelf-life of foods. Nutrition was considered an essential aspect of health care, particularly for mothers and children; the aim was the prevention of all diseases due to malnutrition. He commended in that connection the efforts of UNICEF. As regards diarrhoeal diseases, an expanded control programme was being carried out in Jordan using oral rehydration techniques. Child malnutrition had decreased in the last five to ten years.

An obstacle to Jordan's dental health teams, undertaking fluoride screening and the treatment of mild cases of dental caries in schools, was that they were not permitted to undertake prophylactic work.

His Government attached great importance to road safety: it had introduced compulsory seat-belts, and enforced speed limits on major highways, using radar traps. A major publicity campaign was to be launched for accident prevention, and a national association against traffic accidents had been formed to assist the Government.

Dr OLDFIELD (Gambia) said that, in the area of malnutrition, the developing countries had a poor record; appropriate technology was available but was not properly utilized, as the comments of the delegate of Switzerland relating to growth charts showed.

The relationship between infection, diarrhoea and malnutrition had long been well known, but there had been a failure to apply that knowledge. Nutrition programmes including
nutrition rehabilitation centres were organized vertically and were not properly articulated with other health measures. Food aid programmes were misdirected and frequently lacked the "risk approach". They had great political leverage, but it was used for purposes which, at times, were at variance with clearly defined health objectives and strategies. Action must progress from coping with emergencies to the earlier detection of groups at risk and to the implementation of preventive measures at the village level and in the home. The primary health care approach provided a good model to follow.

Research was needed for the production from locally available materials of weaning foods that could be easily and speedily prepared and that would be free from bacteriological contamination.

The collaboration between WHO and UNICEF in nutritional surveillance and rehabilitation appeared to have an effect at country level; it should be encouraged. FAO could make an important contribution to nutritional surveillance in cooperation with WHO at the primary health care level, but that did not appear to be taking place.

Referring to oral health (programme 8.2) and nutrition (programme 8.1), he said that the changing habits of people in developing countries had brought about dental problems which had once been rare. He asked what practical means could be used to incorporate fluoridation technology in primary health care in rural Africa, given the absence of piped water, the unavailability of toothpaste or the unwillingness of people to use it, and the dangers that accompanied the use of fluoride tablets.

Professor MATTHEIS (Federal Republic of Germany), also referring to oral health in connection with nutrition, noted that mention had been made earlier of the oral health needs of the elderly. Another group not properly covered by dental services, even in industrialized countries, were the severely handicapped, whose oral health problems it was easy to overlook, although the philosophy of keeping healthy what was healthy was even more meaningful for such persons. In her country, special dental services had been set up for the young severely handicapped within the school health services giving instruction and treatment. That also included an experimental cooking course for mentally retarded teenagers, who often not only had very bad teeth but were overweight. As verbal instruction was of limited effectiveness, the teenagers learned about balanced diet by shopping, preparing and eating together. Such efforts were important for the quality of life of that group, however small in statistical terms, and deserved mention as part of primary health care.

Mrs TAGWIREYI (Zimbabwe) welcomed the general thrust of the programme for general health protection and promotion, and in particular the emphasis placed on nutrition. Zimbabwe's nutritional problems included especially protein energy malnutrition. The drought of the past three years had worsened the situation, although some of its effects had been contained through such emergency measures as food relief and supplementary feeding for children under five years of age in the drought-stricken rural areas. Experience during the drought had emphasized the need for an adequate food and nutrition surveillance system to facilitate the planning of timely and appropriate interventions. She noted that the Regional Offices for the Americas, South-East Asia and the Western Pacific were assisting countries in developing nutrition surveillance systems; Zimbabwe looked forward to similar collaboration from the Regional Office for Africa.

Dr WILLIAMS (Sierra Leone) said that her country supported the general health protection and promotion programme. For some time, it had been interested in the formulation and implementation of a national food and nutrition policy, but it was still quite a long way from taking active steps in combating malnutrition, particularly among those under five years old. She asked what WHO and FAO could do to encourage countries, such as Sierra Leone, to grow enough local protein crops, such as beans, beniseed and groundnuts, as well as the local rice, which contained more vitamin B and protein than highly polished imported rice.

Some years earlier a very well-tolerated weaning food, Benemix, had been produced, but unfortunately production had been discontinued because of the lack of raw materials and the inadequacy of machines.

Sierra Leone had one of the highest infant mortality rates in the world, and malnutrition was a major contributing factor; she appealed to WHO and to FAO for help. The importance of nutrition education in primary health care activities had been recognized and she called on WHO and UNICEF for more assistance in that area.

Major contributing factors in the extremely high incidence of traffic accidents were the poor road surfaces and the inadequate maintenance of vehicles; concerted efforts were needed, perhaps with bilateral or multilateral assistance, to get roads in good condition; spare parts for cars were difficult to obtain because of a shortage of cash and foreign
exchange. Assistance was also needed in training drivers in vehicle use and maintenance of road-worthiness.

Dr GRECH (Malta) expressed support for programme 8.1 (Nutrition) with its emphasis on the integration of nutritional activities in primary health care and its focus on infants, children and mothers. A nutrition study carried out in Malta in 1981 and followed up in 1983 had indicated bad nutritional habits, contributing at least in part to the high incidence of cardiovascular disease and diabetes. It showed that malnutrition, whether due to excess or imbalance, was not necessarily linked to affluence; cultural and psychological factors had to be taken into account. Little would be achieved without strong political commitment and the collaboration of the agricultural, trade and financial sectors in accepting a realistic national food policy.

Mr ARCURI (Argentina) expressed satisfaction with the presentation, approach and goals of the programmes and the special emphasis on nutrition; its importance for all aspects of health was well known, as were the pernicious effects of nutritional deficiencies, which were becoming more widespread in certain parts of the world owing to the profound economic crisis directly affecting the developing countries, in some cases exacerbated by recurrent natural disasters, such as had occurred in Africa.

Argentina was traditionally a food-producing country, but certain sectors of the population were faced with severe economic hardship and could not afford the right food for correct nutrition. For some time, the authorities had implemented a series of food-supplementation programmes at national level for the most affected and most economically vulnerable sectors of the population. Food supplements were provided to many families and a large number of school canteens, especially to schools in marginal areas, industrial centres, densely populated areas and those with special health needs. It was hoped that the child growth surveillance programme would be expanded in 1985.

He expressed appreciation for the work on personnel training and training courses, and for the joint activities of UNICEF and WHO mentioned in paragraph 17 of the programme statement. Every effort should be made to support developing countries in their fight against malnutrition, especially among children.

Dr BATCHVAROVA (Bulgaria) said that the situation analysis for nutrition (programme 8.1) showed the gravity of the problem. There were only 15 years left in which to achieve the target for adequate nutrition, but the problem had not yet been solved in most countries of the world, and malnutrition particularly affected vulnerable groups such as babies, children and mothers, whence the great importance of the global programme of assistance to Member States for the establishment of national programmes addressing their specific needs regarding nutrition.

The statistics concerning the victims of iodine deficiency were alarming, especially since medical science was capable of curing iodine deficiency diseases. Bulgaria had 20 years' experience in that area and was willing to share it. The fight against endemic goitre took the form of prophylactic administration of iodine as well as measures to improve general health and hygiene and increase protein intake. Prophylactic administration of iodine had been carried out since 1958, when a decree of the Council of Ministers had ordered that all salt supplied to 14 endemic regions should be iodized. Potassium iodide was added to salt at the rate of 20 mg/kg. Potassium iodide was also administered to some groups in tablet form. Children up to seven years of age were given 0.5 mg per week; children from seven to 18 years of age were given 1 mg per week; and pregnant women and nursing mothers were given 1 mg to 2 mg per week. Large-scale preventive surveys were carried out in kindergartens, schools and factories. Persons with abnormalities of the thyroid gland were sent to health centres for research into and treatment of their condition.

The programme on nutrition emphasized cultural and psychological factors and the lack of information about a balanced diet among the population. For that reason, it was important to coordinate the nutrition programme with the programme of public information and education for health, placing particular emphasis on adequate nutrition and food hygiene.

The relationship between high alcohol consumption and an unbalanced diet was an established fact. Her delegation proposed that high alcohol consumption should be mentioned after the "uncontrolled patterns of consumption" mentioned in paragraph 9 of the situation analysis for programme 8.1. With the increased proportion of old people in many countries, and their special nutritional needs, it also seemed advisable to include that group as a high-risk group along with children, pregnant women and mothers.

In view of the increase in mass catering in schools, factories and offices throughout the world, her delegation proposed that the research on which the programme was to concentrate (paragraph 12 of the programme statement) should include not only "behavioural
aspects of nutrition", but also the nutritional and biological value of new foodstuffs, nutritional aspects of organized mass catering and the effects of new technological processes on nutritional value, food safety, etc.

Dr KLIVAROVÁ (Czechoslovakia) said that in her country an oral health department was attached to all polyclinics, dentists' surgeries and outpatients' departments, and that dentists formed an integral part of the primary health care network. There were also dental departments in hospitals and clinics, with one dentist for every 2500 people. A dental research institute had been in existence for 30 years. Preventive oral and dental care was provided in schools and kindergartens for children from the age of three years. Her country was willing to cooperate fully in the activities under oral health (programme 8.2).

Dr MARKIDES (Cyprus), commenting especially on the control of malnutrition caused by imbalance or excess, said that his delegation strongly supported the projects currently being implemented in Europe and the Americas and would welcome a similar WHO project in Cyprus. Obesity and inappropriate or unhealthy diet were a problem in many countries owing to ignorance of the population and pressure from the food industry via the mass media.

The delegation of Cyprus strongly supported programme 8.3 (Accident prevention).

Traffic accidents were one of the main causes of death, especially in young people. The problem was increasing owing to bad roads, greater number of cars on the road and drunken or reckless driving. In 1985, the Government of Cyprus was to pass legislation on the wearing of seatbelts and breath-testing of drivers. He was glad to see that regional offices were to provide technical support (programme 8.3, paragraph 7), which his Government would welcome.

Professor COLOMBINI (Italy) supported the programme for nutrition, which was so important for the prevention of communicable diseases and their devastating effects, especially in developing countries. He expressed satisfaction with the joint WHO/UNICEF nutrition support programme, to which Italy contributed; he appealed to other countries to combine efforts in order to increase the resources and impact of such programmes.

Professor HUTAS (Hungary) agreed with and supported the objectives, targets and situation analysis for nutrition (programme 8.1), and particularly welcomed the idea of exploring the causes and consequences of deficient nutrition. Standards of food production in Hungary ensured a balanced diet and an adequate choice of food. Nevertheless, as in many European countries, obesity due to an unbalanced diet was not uncommon, even in children, and associated diseases, such as cardiovascular disease and diabetes mellitus, were frequent. The health services had developed a programme to study and analyse the eating habits and nutritional status of the population in a five-year cycle. The present studies were due to end in 1987, and it might be possible for Hungary to contribute to the activities outlined in paragraph 20 and to share the experience it had gained.

His delegation also supported the statement in paragraph 22 concerning the role of the joint WHO/UNICEF nutrition support programme in reducing infant mortality and morbidity. Even industrially developed countries needed health education and support to encourage breast-feeding and improve the eating habits of parents and children.

Dr TRAGORE (Mali) endorsed the support expressed by previous speakers for programme 8.1 (Nutrition), which was especially important to Mali as one of the Sahelian countries affected by drought.

He wished to draw particular attention to three aspects of the programme. The first, food production and quality, should be studied in intersectoral collaboration between ministries of health and ministries of rural development. Ministries of health had the power to evaluate the state of nutrition of various communities and make recommendations, which the ministries of rural development should take into account in order to encourage production of appropriate crops.

The second aspect was that of education for health. The first signs of malnutrition most frequently appeared when a child was weaned: it was not always due to lack of food alone but also to inappropriate use of available food owing to cultural factors.

Thirdly, nutrition surveillance should form a part of the everyday work of health services, in order to ensure early diagnosis of malnutrition and appropriate and timely treatment.

Dr AL-MAZROU (Saudi Arabia) also supported the nutrition programme. The discrepancies between food production and its distribution in the world could not be ignored, and countries looked to WHO for action in that regard. Saudi Arabia was trying to grow its own food,
although it was expensive to produce. It had succeeded in becoming self-sufficient in wheat and other major foodstuffs, and exported surplus produce to help other countries, with the coordinating assistance of WHO and FAO.

His delegation shared the concern of previous speakers about the increase in traffic accidents in developed and developing countries. Increased emphasis on programme 8.3 in 1986-1987 would help to reduce such accidents.

Professor CEVIK (Turkey) stressed the importance of teaching oral hygiene through primary health care, especially in developing countries, and strongly supported the oral health activities proposed (programme 8.2).

Surveys carried out in schools in the less-developed parts of her country had revealed dental caries in almost 90% of the children, while in children living in districts where conditions were better the figure was about 74%. Dental caries was also very prevalent among the adult population. Neglect and poor nutritional habits were the main causes of dental problems.

A start had been made within the context of primary health care on teaching oral hygiene to school children and "mouth and dental care" hospitals had been opened in some of the larger cities to provide treatment. Health workers were urging that oral hygiene should be started from the earliest age, providing information about a balanced diet and cautioning against the inclusion of too much carbohydrate in the diet. Efforts were also being made to promote such teaching through broadcasting and television.

Dr SIAMEV (Togo) said that the problem of malnutrition was very serious in the African Region, due, inter alia, to the shortage of foodstuffs resulting from the aridity of much of the land, the poor quality of agricultural implements and climatic hazards. No less important causes were taboos and poor diet due to ignorance of the nutritional value of what food was available. The nutritional needs of children were also misunderstood. Those adverse factors were often aggravated by the presence of intestinal parasites in children and alcoholism in adults. His delegation therefore considered that the greatest importance should be accorded to the achievement of self-sufficiency in food production and to the nutritional education of the population.

Dr PAHARI (Nepal) welcomed WHO's cooperation with UNICEF in combating the serious problem of malnutrition, which was of concern to all.

He stressed the importance of eradicating the factors underlying malnutrition. The provision of food, vitamins and milk was of little value if people did not understand how to use them. He therefore urged WHO to make every effort to cooperate with other United Nations agencies in teaching people about nutrition and helping them to achieve self-reliance in that respect. Only in that way would it be possible to achieve the goal of health for all by the year 2000.

Dr HAJAR (Yemen), stressing that nutrition was one of the most important elements of primary health care, said that in his country a nutrition unit had been established, which had organized a symposium for people in charge of various sectors. Moreover, 1984 had been declared the Year for Agricultural Development, and a Supreme Committee for Nutrition had been set up, representing various sectors of the economy, such as agriculture, education, health and the General Cooperative Union, to work on food problems.

Attention had also been given to combating diarrhoeal diseases, through legislation regulating the use of natural milk substitutes and the encouragement of breast-feeding. School children, who constituted more than one-sixth of the population, were being educated in oral health.

Accidents were now one of the main causes of mortality in Yemen, especially among young people. Accident prevention would require technical support and other assistance from WHO.

Dr McHARDY (Jamaica) said that, as there was a high incidence of dental caries in his country, attempts had been made to fluoridate the water supply, but that solution had been found to be prohibitively expensive. There was also the difficulty of reaching the many small and remote rural water supply systems. Consideration had therefore been given to the incorporation of fluorides in table salt, which was produced by Jamaica's single salt factory. PAHO had provided the funds for an engineer from the factory to visit Switzerland to make enquiries about the possibility of doing so and it had been found that that process would add very little to the cost of the salt and would be much cheaper than water fluoridation. The Ministry of Health was in favour of the project, but Government approval had yet to be obtained. He had brought that subject to the attention of the Health Assembly as so little mention had been made of that method of ensuring oral health.
Dr REZAI (Islamic Republic of Iran) strongly supported the oral health activities proposed in programme 8.2. As oral diseases were not a significant cause of mortality and disability, priority had not so far been given to oral health in developing countries. As a result, dental caries was increasing in many of them, particularly in the younger age-groups. Lack of preventive techniques and a shortage of dentists meant that the implementation of oral health programmes faced many problems.

In his country, efforts were being made to overcome those problems. A special school for oral health technicians had been established in 1982, providing a three-year course. It was expected that before long all rural health centres would have an oral health technician on the staff who would provide curative and restorative services. Plans were also under way to fluoridate water in areas where that was needed.

Dr UNSAL (Turkey), while supporting programme 8.3 (Accident prevention), stressed the need for preparedness for dealing with natural disasters, which could have serious physical and psychological effects on health. WHO should initiate a special programme for training people working in primary health care to deal with natural disasters. Perhaps that might be included in programme 11, on the promotion of environmental health.

Dr BROTO WASISTO (Indonesia) said that during the last 15 years his country had made significant social and economic progress. Industrial, agricultural and other development centres had been opened up, followed by the construction of roads to make them accessible to market activities. The resulting increase in motor traffic had led to an increased incidence of traffic accidents, reflected in an increase in admissions of emergency cases to hospital of some 10-15% annually over the last two or three years. Such accidents represented a burden on the health services and a consequent socioeconomic loss.

The causes of traffic accidents were complex and the solution of the problem required an intersectoral approach. The delegation of Indonesia supported WHO - and would appreciate its assistance - in the proposal to improve the capability of Member States in carrying out research on traffic accidents. It believed that the solution to the problem called for the integration of accident prevention into urban primary health care through the provision of information and education.

Dr MAGNUSSON (Iceland) supported the proposals under oral health (programme 8.2). A recent study of the oral health of children in his country had revealed that, although school dental services had been considerably augmented during the last 10 years, the fact that they had concentrated on treatment rather than prevention meant that they had not succeeded in reducing the incidence of dental caries. That experience brought clearly into prominence the need to focus on prevention through community and public health education. His delegation therefore welcomed the emphasis on prevention in the oral health programme.

A new and promising development was being explored, namely the use of a simple test to isolate a bacterium, Streptococcus mutans, in saliva, which might help to identify the approximately 10% of children who ran a higher risk of dental caries.

Dr MONEKOSSO (Regional Director for Africa), replying to the request of the delegate of Zimbabwe for support to countries in nutritional surveillance, said that the Regional Office for Africa was already cooperating with many countries in that field. Much more remained to be done, however, and the Regional Office was ready to take appropriate action to help Zimbabwe.

With regard to the question by the delegate of Sierra Leone about WHO action, in collaboration with FAO, to assist countries in food production, he reminded the Committee that the Joint FAO/WHO/OAU Regional Food and Nutrition Commission for Africa had been established many years previously. The fact that the question had been asked might perhaps indicate that it had not been accomplishing its task with sufficient efficacy. He assured the delegate of Sierra Leone that the Commission would be giving particular attention to ways of helping countries to reach self-sufficiency in food production.

Mr PUNA (Cook Islands) expressed general support for the proposed programmes, in particular those relating to alcohol abuse and its influence on road accidents. Hospital resources were being wasted in his country in dealing with the consequences of such accidents. He was also pleased that it was proposed to deal with community water supply and sanitation; that was a matter of priority in his country because it affected not only the promotion of health but also the development of agriculture and tourism.

Dr PETROS-BARAZIÁN (Director, Division of Family Health) emphasized the importance of an integrated approach to nutrition in primary health care with particular reference to
mothers and children. Replying to questions raised by the delegate of Switzerland and other delegates in connection with the nutrition of mothers and children, she said that that was obviously a priority issue since nutrition played a decisive role in reducing mortality rates in that vulnerable group.

In practical terms, the Organization, in addition to ensuring the structural proximity of the two programmes in one Division, had endeavoured to forge close functional links between them. They had necessarily also to be related to all other programmes directly affecting the health of mothers and children, such as those concerned with the control of infectious and diarrhoeal diseases. Consequently, the twin programmes of nutrition and of maternal and child health had to rely on other programmes in the Division as well as in other divisions at all levels of the Organization. Hopefully, that functional linkage of all programmes would enable the wish expressed by a number of delegates for an integrated approach to be met.

Referring to the appeal made by the delegate of Italy in connection with the joint WHO/UNICEF nutrition support programme for developing countries, she welcomed that appeal and thanked the Italian Government for its generous contribution in that field. She also wished to thank the Government of Belgium for its support of a similar programme known as the Belgian Fund for Survival in the Third World.

Dr PRADILLA (Nutrition) said that one of the major problems in the field of nutrition was that it required the concurrence of many other disciplines, not only within the health sector but also in the context of national development. There was therefore no single specific activity that could provide a total answer to nutritional problems. WHO's programme had been drawn up with that in mind and referred mainly to those activities in the health sector which would make an impact on nutrition, but it also took into account those activities concerning nutrition which should be included in programmes at all levels of the health system. Every effort was being made to harmonize programmes, particularly within the United Nations system, so as to achieve maximum efficiency and the best results. The support of the Belgian and Italian Governments had been instrumental in facilitating the integration of the work of the various United Nations agencies at country level. With the support of the Italian Government, joint UNICEF and WHO action had been taken, while the Belgian Fund for Survival in the Third World had helped to integrate IFAD, UNICEF, UNDP and WHO programmes in truly multisectoral activities at country level.

Growth monitoring and nutrition surveillance, which had been referred to by several delegates, were essentially tools. Their use required the requisite follow-up action, but unfortunately that did not always happen. The Director-General and his staff, in cooperation with field offices, had been endeavouring to develop a series of options based on experience at country level in order to respond to the findings of poor growth or excessive growth in children.

Several publications and documents were planned in conjunction with maternal and child health. The first would appear in the current year and would be a new version of the publication on growth monitoring. The following publication would deal with the action-oriented approach to growth failure. The third - on nutrition and its associated factors: assessment for planning - would concentrate on community assessment of the nutritional status and monitoring of the community situation. It was impossible to set forth global measures applicable everywhere, but some indication could be given as to the options available in any given situation and those options would be outlined in that publication.

The training and supply of the necessary health personnel also raised major problems. In too many cases, they served the needs for university teachers and research better than for those who fought ill-health in the field. That matter required further study. In conjunction with other bodies, the Organization had been directing its efforts towards finding out the exact tasks of health workers, how those tasks were performed and the aims they were meant to achieve to respond to people's needs. It should then be possible to design curriculum contents for more useful training directly related to problem solving.

Referring to iodine deficiency diseases, he said that no one could be unaware of the efforts that were being made to bring them under control within the next decade. In the context of the joint WHO/UNICEF nutrition support programme and with the help of the Italian Government, a specific programme was being carried out in Bolivia, Ecuador and parts of Peru.

In reply to the request by the delegate of the Libyan Arab Jamahiriya, he recalled that, in response to resolution WHA37.18 and initial funding having been provided from the Director-General's Development Programme, WHO had prepared a comprehensive draft ten-year programme of support to countries for the prevention and control of vitamin A deficiency, xerophthalmia and nutritional blindness. That draft programme was closely linked to the

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blindness prevention programme. WHO's proposed programme stressed the short-term measures that the health sector could take using existing primary health care facilities. It also advocated a flexible intersectoral strategy combining short-, medium- and long-term actions and nutrition education. The proposal had been initially sent to 21 governments and two regional intergovernmental bodies, and to FAO, UNDP, UNESCO, UNICEF and the World Bank, which had been invited to a meeting of interested parties held in Geneva on 12 March 1985. The purpose of that meeting was twofold: to provide information on the steps the Organization was taking to give effect to the Health Assembly's resolution, and to initiate the process of mobilizing financial and other resources for that purpose. In addition to representatives of governments and government-sponsored agencies, and agencies and bodies of the United Nations system, participants included representatives of nongovernmental organizations and experts active in the prevention and control of vitamin A deficiency, and the chemical industry—producers of vitamin A.

There was unanimous agreement at that meeting that WHO was, and must remain, a major force and catalyst in promoting nutritional blindness prevention, and that it had a vital role to play in coordinating and harmonizing the efforts of all interested parties to ensure that they had the greatest impact. By maintaining an up-to-date global needs inventory, WHO was able to identify and call attention to gaps in prevention and control programme coverage. Governments had the opportunity of making voluntary contributions to WHO to fill those gaps, or might wish to fund prevention and control programmes on a direct bilateral basis. In the latter case, it was essential that WHO be kept informed of all support provided in order for it to play its assigned coordinating role.

WHO proposed to launch that proposed programme publicly in September, and among preparatory measures to that end, it was assembling a kit containing a variety of feature articles, case studies, prevalence data and other relevant information.

WHO was confident that sufficient interest would be generated for governments to provide the necessary resources. So far, only one country, the Libyan Arab Jamahiriya, had made a voluntary contribution, while another, Switzerland, had indicated that it was willing to consider funding prevention and control activities on a direct bilateral basis.

Iron-deficiency, causing anaemia, was different from vitamin A and iodine deficiency. No single programme had provided a good response in mass interventions. WHO was cooperating with various international nutritional and anaemia consultative bodies with a view to finding appropriate solutions.

The other area referred to by several delegates concerned child feeding. The nutrition programme emphasized the current research carried out to ascertain why mothers fed their children the way they did. WHO was supporting some country programmes in that field. Education alone was insufficient to change the patterns of infant feeding and a variety of socioeconomic factors had to be considered. He expected that a series of research papers, to be prepared during the following two years, would throw some light on the reasons underlying infant feeding patterns.

Dr AL-MAZROU (Saudi Arabia) said that WHO's recommendations carried great weight. He therefore suggested that the Health Assembly should make two recommendations: firstly, it should recommend natural breast-feeding, and secondly, it should emphasize the dangers of driving under the influence of alcohol.

Dr BARMES (Oral Health) said that three questions called for a reply. First, it was opportune that a question had been asked about fissure sealants, because that methodology could have an important bearing on the incorporation of oral health in primary health care, as called for in Dr Borgoño's programme introduction. Fissure sealants were acrylate resins which formed a durable bond with tooth enamel following mechanical cleansing and conditioning with a phosphoric acid solution. They were effective in preventing dental caries in the pits and fissures of molar and premolar teeth, which were the most common sites of dental caries lesions once the severity of the disease had dropped below the 3 DMF (decayed, missing and filled) teeth-at-12-years benchmark. However, the lowest estimate of costs was US$ 1.20 per tooth in countries where the sealants were actually produced. Also, the methodology, though simple required meticulous care, trained personnel and physical conditions that might be difficult to achieve consistently in developing countries. Thus, a proven preventive methodology was available that could be very appropriate to primary health care activities in developing countries, but for which development of a special strategy was needed. When it was considered that the average 12-year-old in many developing countries had only two carious lesions in permanent teeth in the first six years after eruption, application of sealants to all molar and premolar teeth in all children could be prohibitively expensive. WHO was therefore trying to develop a strategy involving a programme of selective sealing, preferably by primary health care workers using an even simpler system than was presently available. If
that aim could be achieved, it would mean a balanced primary health care approach for oral health based on health education towards an optimal use of fluorides, oral hygiene and prudent diet, and on simple preventive interventions by primary health care workers: namely, scaling to control periodontal disease and sealants to control caries.

The second question concerned the problems of the elderly. Those relating to oral health, particularly to near or total edentulousness, were a growing concern as the demographic pattern changed and as prevention became more and more effective for children and young adults. Special efforts that WHO might make in that area were now being considered, particularly measurement of the problem, self-help aspects, periodontal disease management and the high technology or precision type of prosthetics which that particular group required. A consultant would be available for four months later in the current year to advise the programme how to deal with the problem. For some years WHO had been directing the attention of the dental profession to the question, both for fundamental training changes and for innovative and extensive services; but it was hoped that more intense efforts would ensue in collaboration with the global programme for the health of the elderly, for which the medium-term programme for 1988-1989 included a monograph on oral health for the elderly.

It was also hoped to include services for the handicapped in efforts to improve services for the elderly. A pilot study had been started on hospital dentistry and dental services for the institutionalized, since it was felt that in hospital dentistry there had always been too much emphasis on out-patient services and too little on in-patient care and maintenance.

The third question concerned the application of fluoride in areas where water fluoridation was difficult or impossible to introduce and where toothpaste was not particularly popular. WHO was very keen on the application of fluoridated toothpaste, which had the advantage of being applied exclusively by the individual. However, to attain a widespread use of fluoridated toothpaste was a very slow process in many countries. A recommended alternative was fluoride rinsing programmes in schools, which were simple and inexpensive and could be organized on a community basis. Also, salt fluoridation, which had been mentioned by the delegate of Jamaica, stood side by side with water fluoridation as the most effective of the centrally controlled methods and was applicable to the situation in many developing countries. As indicated in response to the first question, sealants were also a possible alternative.

In conclusion, Dr Barmes said that the Organization was having great difficulty in servicing the ever-increasing demand from Member States for cooperation in the field of oral health, to the extent that hard options had to be taken to use those resources which were available for services which could not otherwise be provided. Emphasis was therefore being placed on informatics and management/administration, because the specific dental expertise needed by the oral health programme could come from the very cooperative nongovernmental organizations related to oral health, such as the International Dental Federation, as well as through the international collaborative oral health development programme if only Member States would throw themselves behind that all-too-slowly developing programme and thereby provide the means for its dynamic and effective administration.

Dr ROMER (Accident Prevention) said that, although few questions on accident prevention had been raised, some points needed clarification. It had been said that the content of the accident prevention programme might seem very ambitious in view of its resources, but he believed that the content reflected priorities essential to the development of a programme capable of responding to the needs of Member States, and that it seemed to fall within reasonable limits. He was, however, well aware of the limitation of resources; and he stressed that most, if not all, activities of the programme were not being undertaken in isolation but in close coordination and cooperation with several interorganizational programmes or programmes of governmental or nongovernmental organizations. That was the very essence of the programme, which was, as it were, a platform for the promotion of a certain number of activities outside WHO, in so far as many technical aspects of accident prevention were not directly under WHO's responsibility.

In that regard he mentioned the close cooperation established with the maternal and child health programme in the area of accidents to children and adolescents which, given the epidemiological importance of the problem, formed a major priority of that programme. A coordinated research programme on the epidemiology of accidents to children was also under way in the Region of the Americas and would probably be extended to all WHO regions within the next two years. In the field of alcohol and drug abuse the question had been raised several times; there too, close collaboration had been achieved, not only with the mental health programme but also with nongovernmental organizations highly active in the field. Finally, collaboration had also been established with the programme for the health of the elderly, given the increasing importance of research on accidents in that segment of the population.
He also stressed the increasing involvement of the regions in accident prevention, and the considerable support furnished by the regional offices: although globally the programme budget had remained substantially the same, there had been a strong increase at regional and country level.

Replying to points raised by the delegates of Yemen and Sierra Leone concerning the importance of road accidents and problems of infrastructure, he said that discussions had been opened with the World Bank to arrive at a coordinated operational approach at country level, since the World Bank, which had a road transport safety programme, represented the departments of transport and was essentially concerned with infrastructure problems which were not directly of concern to WHO. In the relatively near future he hoped that cooperation would be undertaken between the two agencies, which perfectly complemented each other: one in the area of infrastructure and the other in the more human aspects of the question.

Replying to the reference by the delegate of Indonesia to research, he said that it was a major concern of the programme to promote research in certain sectors, notably on child accidents and accidents among the elderly. The programme was also trying to develop a network of national research institutions, particularly in the field of transport, and to establish close coordination at country level between those research institutions and national research institutes in public health.

CONSIDERATION OF A DRAFT RESOLUTION

Regional programme budget policies

The CHAIRMAN said that consideration of programme 8 had been concluded. Before continuing with programme 9, he drew the Committee's attention to a draft resolution on regional programme budget policy, which was presented by the delegations of Australia, Canada, Denmark, Finland, France, Iceland, Kenya, Malta, Netherlands, New Zealand, Norway, Oman, Sweden, Union of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, United States of America, and Yugoslavia. The draft resolution read as follows:

The Thirty-eighth World Health Assembly,
Recalling numerous Health Assembly resolutions concerning programme budget policy, WHO's international health work through coordination and technical cooperation, and the functions and related structures of WHO, and in particular resolutions WHA29.48, WHA30.23, WHA33.17 and WHA34.24;
Having considered resolution EB75.R7 on regional programme budget policies;
1. STRONGLY SUPPORTS the preparation of such policies by the regional committees as requested by the Executive Board;
2. URGES Member States to assume their responsibilities for the preparation and implementation of such policies;
3. ENDORSES the Board's decision to monitor their preparation, as well as to monitor and evaluate their implementation in conjunction with the biennial budget reviews, and to report to the Health Assembly thereon;
4. DECIDES to monitor and evaluate their implementation in the light of the Executive Board's reports thereon;
5. REQUESTS the Director-General to provide full support to Member States and to the Health Assembly, regional committees and Executive Board, for the preparation, implementation, monitoring and evaluation of the regional programme budget policies.

Dr REID (United Kingdom of Great Britain and Northern Ireland), introducing the draft resolution, said that it was a very simple one, derived from two different sources. The Director-General in his initial Introduction to the programme budget had envisaged a 4% increase in budgetary allocations at country level; yet in the same Introduction he had been frankly and forthrightly critical of at least part of the way in which WHO's limited resources had hitherto been used. The Director-General had called on Member States to accept collective responsibility for the use of those limited resources, and had specifically proposed the adoption of regional programme budget policies.

The second origin of the draft resolution lay in the draft guidelines for regional programme budget policies contained in document A38/INF.DOC./1, to which was attached a paper
from the Director-General's office. As Dr Cohen had pointed out the previous week, the entire contents of the document were consonant with the existing policy decisions of successive Health Assemblies.

Earlier interventions, both in the Committee and in plenary, had pointed to the need to respond to those two issues, and the draft resolution was being presented for that reason. Its preamble recalled the substantial number of resolutions passed by the Health Assembly on relevant matters: for example, resolution WHA29.48 had called for a reorientation of the working of WHO to ensure that at least 60% of the regular budget was devoted to technical cooperation and provision of services and had also requested that projects which had outlived their utility should be phased out. The same resolution had asked the Executive Board to pay special attention to such matters in future reviews of programme budgets.

The second resolution mentioned in the preamble, resolution WHA30.23, had adopted new programme budgeting procedures and presentation, which were currently in use. Operative paragraph 1(4) of that resolution required the Executive Board and the Health Assembly to play what was at that stage understandably an elementary monitoring role in relation to the implementation of the programme budget. Monitoring had thus first appeared in a resolution in distinct form in 1977.

The next resolution mentioned, resolution WHA33.17, covered, inter alia, the concentration of the Organization's activities in support of national, regional and global strategies for attaining health for all. Operative paragraph 1(7) referred specifically to the Health Assembly's constitutional authority for determining policies and increased its monitoring functions with respect to the work of the Organization, including the follow-up and review of the implementation of resolutions. The Executive Board had also been requested, in operative paragraph 4, to monitor on behalf of the Health Assembly the way the regional committees reflected the latter's policies in their work.

Finally, he drew attention to resolution WHA34.24, also mentioned in the preamble, which stressed WHO's leadership as the directing and coordinating authority on international health work and requested the Executive Board to ensure that the Organization's activities and programme budgets fully reflected WHO's international health work in a properly balanced fashion.

The preamble thus indicated that there was nothing new whatsoever in the draft resolution, which was merely an attempt to sharpen and give point to the existing resolutions and the debate of the previous week.

Referring to operative paragraph 1 of the draft resolution, he said that it simply agreed with the Director-General that there should be regional programme budget policies: operation without them was impossible. Operative paragraph 2 reminded Member States that they should play their part in the preparation and implementation of such policies. He stressed that operative paragraphs 3 and 4 did not in any way usurp the sovereign rights of Member States in arriving at their individual health policies but, as far as the WHO regions were concerned, it was essential that collective policies were in line with the decisions arrived at by Member States in the Health Assembly.

As he had pointed out, the concept of monitoring and evaluation was not new: such processes were no more than prudent common sense in relation to any health priorities, national, regional or global. It was constitutionally in keeping with the role of the Executive Board that it should undertake the preparatory work in the monitoring and evaluation process. For that reason, he hoped that the Committee and the Health Assembly would support the draft resolution, which was fully in keeping with the policy of the Organization and with successive resolutions of the World Health Assembly.

The CHAIRMAN asked if there were any comments on the draft resolution.

The draft resolution was approved.

The meeting rose at 12h30.

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1 Document WHA38/1985/REC/1, Annex 3.
2 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA38.11.
SIXTH MEETING

Monday, 13 May 1985, at 14h30

Chairman: Dr D. G. MAKUTO (Zimbabwe)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1986-1987: Item 22 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II) (continued)

PROGRAMME POLICY MATTERS: Item 22.2 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II, Chapter II) (continued)

Health science and technology - health promotion and care (Appropriation Section 3; Documents PB/86-87, pages 106-199; EB75/1985/REC/1, Part II, Chapter II, paragraphs 37-56; A38/INF.DOC/3, A38/INF.DOC/4 and A38/INF.DOC/7)(continued)

Protection and promotion of the health of specific population groups (programme 9)

Dr DE KOCK VAN LEEUWEN (Netherlands) stated that his delegation was gratified by the importance being given by WHO to the issues of family health, human reproduction and family planning. His Government fully supported the view that the importance of the early years of life to the health and wellbeing of adult populations could not be overemphasized. Investment in maternal and child health was, indeed, a direct entry point to improved social development and socioeconomic productivity. Consequently, to ensure the health of mother and child both before and during pregnancy, in childbirth and throughout childhood should be a permanent concern of all countries (paragraph 3 on page 124 of the programme budget).

His delegation felt strongly that WHO should continue to lay stress on the prevention of childbearing at too young an age, on the need for an adequate interval between births, and on avoiding excessive multiparity, especially after the age of 35 when obstetric and perinatal risks increased markedly (paragraph 7 on that same page).

Appreciation of the fact that the social and economic status of women was crucial to the health of children, women and families had led his Government to have equally strong views on the positive health benefits of family planning and on the possibility for couples to regulate their own fertility, which was one of the major determinants for enabling women to participate more fully and equitably in socioeconomic development (paragraph 8).

Both human reproduction research (programme 9.2), and maternal and child health, including family planning (programme 9.1) should play a permanent role in those developments. His delegation had great confidence in the start made by programme 9.2 and commended its new management on achievements so far. At the same time, his delegation felt that some improvements could be introduced, notably with regard to health services research and to policy analysis, with a view to achieving the integration of family health, family planning and population policies as an overriding concern in maternal and child health policies and regional social and economic policies. Progress was being made in that regard, for example, by programmes in Indonesia, China, Singapore and elsewhere.

His delegation had, however, been struck by what appeared to be a somewhat low level of commitment under the regular budget to those programmes, especially human reproduction research (programme 9.2), in relation to the high extrabudgetary contributions. His Government would welcome a budget better balanced in that respect. Such a balance would be particularly appropriate in that it would bring the priority attributed to that field by WHO, both verbally and in documents, into line with its material commitments and would in no way detract from the cooperation with UNFPA, the World Bank and others, since a strong regular budget for such programmes would benefit all concerned and enhance the long-term viability of the programmes.

He was happy to inform the Committee that, since the previous session of the Health Assembly, legislation implementing the International Code of Marketing of Breast-milk Substitutes had been developed in his country and had come into effect, so that exports from the Netherlands of breast-milk substitutes were now controlled in conformity with the Code.
His Government asked to be informed if any governments were to find that breast-milk substitutes produced in the Netherlands did not conform with the Code. He reiterated that the Netherlands Government had not found it possible to withdraw its reservations with regard to Article 9.2 of the Code.

Dr SULAIMAN (Nigeria) endorsed the remarks made by the previous speaker.

His delegation fully supported the programme articulation; many specific programmes relating to the health of the family were covered separately. As to the maintenance of the health of mothers and children, he believed that, in the spirit of the United Nations Decade for Women and of International Youth Year, the Health Assembly should focus attention on: the impact of early pregnancy on adolescence, before biological and social maturity; and on population, health and development. His delegation would be submitting a draft resolution aimed at promoting the health of mothers and of children, especially in adolescence between the ages of 10 and 19. That draft resolution would deal with maturity before childbearing and with the promotion of responsible parenthood.\(^1\)

His delegation would welcome clarification as to the relationship between the programme on human reproduction research (programme 9.2) and population, health and development activities. It would not appear at first sight that there was an adequate action-oriented programme within the family planning component at the country level, and so population, health and development should be given greater prominence.

As progress was made towards the target of health for all by the year 2000, changes in population structure and characteristics would be perceivable: population growth would accelerate in response to action aimed at reducing morbidity and mortality; there would be increases in young population, with a greater dependency rate; and the proportion of elderly people would grow as a result of the lengthening of life expectancy, with consequent effects. Population growth and its impact on social and economic development had become a matter of concern in many developing countries. The crisis in the health sector itself was related to the increased demand for health care resulting from rapid growth of the population, and especially of its dependent sectors, such as, for example, unwanted pregnancies, the abandoned and handicapped babies that were the outcome of adolescent pregnancies, as well as the problems of an aging population with chronic diseases. Furthermore, rapid industrialization was creating new environmental health problems, as well as increased migration and urbanization, thus placing undue pressure on health care and limiting the health resources available to the rural communities. It should also be borne in mind that a higher proportion of youth among the population had led to better appreciation of health care, as a result of education, while high unemployment had greatly reduced the ability of individuals and communities to pay for their health care.

It had accordingly become obvious that it was necessary to pursue balanced health development which would take into account such demographic implications and would aim at a population replacement level of growth in the spirit of the Mexico City Declaration on Population and Development. Consequently, if the target of health for all were not to become a mirage as the result of galloping population growth, population, health and development activities should be given the priority they deserved and appear as a separate programme in the programme budget backed by sufficient allocation of funds.

He agreed that activities related to family planning, which was one of the most potent weapons in reducing maternal and infant mortality since it reduced the number of pregnancies and births with their consequential effects, should be undertaken within the family health programme.

In urging the Health Assembly and the Director-General to give population, health and development activities greater priority as part of the health-for-all strategy, he pointed out that his own country had embarked on such a programme, with the assistance of USAID and the World Bank, in order to introduce a stabilizing factor in the national efforts being made to improve the quality of life of the Nigerian people.

Dr MELLBYE (Norway) supported the observations made by the delegate of Nigeria in relation to maternal and child health.

Commenting on the programme for the health of the elderly (programme 9.4), he drew attention to the paradoxical situation existing in many developed countries where, on the one hand, the elderly were encouraged to take an active part in society for as long as possible but were, on the other, being pensioned off at an increasingly early age. He was aware that in many countries with other cultures old age carried prestige by virtue of the experience and wisdom gained. However, in many others, a more ambivalent attitude prevailed.

\(^1\) For text, see p. 132.
His own country supported the objectives and targets of WHO's programme for the health of the elderly. He would make a plea for the integrity of individuals to receive full attention, since that sector of the population was sensitive of constituting a burden. Age was not, after all, a disease, and old people wanted to be provided with ordinary good primary health care, without any positive or negative bias. Indeed, if they were provided with the right tools, they could largely care for themselves.

Dr HASSOUN (Iraq) asked what was the Organization's position on the integration of workers' health activities (programme 9.3) in primary health care along the same lines as maternal and child health, and the health of schoolchildren, of the elderly and of other vulnerable groups, so that care could be provided throughout the lifespan of the individual, a point that had been discussed at the seventy-fifth session of the Executive Board. He believed that such integration would constitute sound practice both in respect of rural and urban areas, and particularly in the developing countries where a number of interrelated problems, with a bearing on nutrition – addiction, for instance – had arisen as a result of the drift of population towards the towns.

He referred to the activities of the national centre for occupational health and safety which had been established in his own country, and which acted in collaboration with industry, and relevant ministries and government departments. He welcomed the support given in that field by the Regional Office. With that support a regional seminar on occupational health in rural areas had been held in Baghdad, in December 1984, at which the integration of occupational health care into primary health care had been discussed. A training course for middle-level workers in occupational health was to be held in September 1985, under the auspices of the Regional Office, the Ministry of Health and the centre. The Regional Office was at present in the process of evaluating the action of that centre with a view to the possibility of its designation as a WHO collaborating centre.

He expressed deep appreciation for the programme as a whole and for the increased budgetary allocation for 1986-1987.

Dr TSHABALALA (Swaziland) wished to draw particular attention to the reference, in paragraph 5 of the programme statement on maternal and child health, including family planning (programme 9.1), to the decline in breast-feeding.

In her own country, a breast-feeding campaign group had been established, consisting of both governmental and nongovernmental members. An extremely disturbing trend had been noted in Swaziland over the past two decades, when the percentage of infants aged from 0-3 months receiving breast-milk substitutes had risen from 4% to 44%. A similar trend was visible in many developing countries. It had thus become clear that mothers who could breast-feed should be supported, by such means as encouraging hospitals and health institutions to ensure that breast-feeding was started in time. Furthermore, it was important to stop the promotion of breast-milk substitutes in health institutions.

While the International Code of Marketing of Breast-milk Substitutes did include restrictions in that regard, under Article 6.6, the matter did not appear to be adequately covered, since the practice of donating large quantities of breast-milk substitutes to hospitals for feeding newborn infants was widespread. That effectively undermined breast-feeding and interrupted the natural development of togetherness between mothers and their babies for love, warmth and food, which was so essential.

Her delegation would urge the Director-General to convene a meeting involving WHO, UNICEF, scientific authorities and nongovernmental organizations, so as to clarify the scope of the Articles of the Code relating to that practice. The task was urgent, since every day lost meant that yet another infant was unnecessarily fed on artificial milk, rather than on the natural and ideal food it deserved.

Dr MARUPING (Lesotho) welcomed the general thrust of programme 9.1 (Maternal and child health, including family planning). In her country, as in most others in Africa, women and children constituted nearly two-thirds of the entire population and, owing to their special health needs, must continue to be given priority in efforts to achieve the health-for-all target.

Her Government was putting much effort into building up health facilities, primarily in unserved and underserved rural and periurban areas: for a population of about 1.4 million people a network of over 120 clinics and 18 general hospitals should, if properly staffed and managed, make an appreciable positive impact on the health of the people. Maternal and child health and family planning were a major component of the services provided in the clinics, and it was therefore extremely important that those centres should be staffed by personnel well trained in providing comprehensive maternal and child health services, including family planning. She appealed to WHO, with its usual partners in health development, to accelerate
efforts for the training of maternal and child health and family planning personnel and other staff in related sectors. Emphasis should be placed on training personnel in technical, management and communication skills, as well as in the appropriate team approach, so that mothers and children were not dealt with in isolation, for instance, by having different clinic days and separate places of attendance. Time, energy and effort should be optimized, especially in view of the long distances that mothers had often had to travel to a clinic. Her delegation considered that the training of personnel in appropriate methods of service provision and management was an area requiring emphasis and accelerated implementation.

Dr MAFIAMBA (Cameroon) said that the programmes on maternal and child health, including family planning (programme 9.1), and on human reproduction research (programme 9.2) had been very well prepared, as indeed they should have been in view of the important role played by WHO in persuading the International Population Conference, held in Mexico, in 1984, to adopt the objectives of reducing infant mortality to 50 per 1000 live births and reducing maternal mortality by half by the year 2000.

His delegation agreed with the situation analysis, the proposed priority areas and the major emphasis to be laid on training and training materials and the strengthening of national programmes. On the other hand, it was concerned by the weakness of those two programmes: they relied almost exclusively on extrabudgetary resources for their execution. If it was borne in mind, as was admitted in the programme budget itself, that voluntary contributions had been decreasing since 1980, it was indeed doubtful whether WHO would be able to carry out the very ambitious programmes presented. Accordingly, the Organization should commit itself to assigning more regular budget funds to those programmes.

As the Minister of Health of Cameroon had stated during the debate in plenary session on items 10 and 11 of the agenda, it was to be hoped that the considerable information and literature generated by research and scientific meetings in the areas of maternal and child health and human reproduction research would be promptly diffused to the periphery, so that they could have the maximum impact at the grass-roots level in developing countries.

Dr AL-JABER (Qatar), referring to programme 9.1, observed that the Director-General had rightly told the plenary Assembly that "lip service alone will not get us very far"; although considerable progress had been made with the promotion of breast-feeding and plans to implement the International Code of Marketing of Breast-milk Substitutes, more than lip service was needed, and his delegation would like to hear more about WHO's plans to hold a technical meeting, together with UNICEF, which would clarify some of the "grey areas" of the Code. It was to be hoped that such a meeting could be held during 1985, so that its recommendations could be included in the report to be submitted by the Director-General the following year. In the light of the Technical Discussions at the current session, it was not only appropriate but essential that such a meeting should involve the nongovernmental organizations which had been monitoring the implementation of the Code for a number of years. With regard to the reference to timely and appropriate weaning practices as an essential element in the improvement of maternal and child health, perhaps the Committee could be informed of the steps that had already been taken in pursuance of resolution WHA37.30 and the plans that were being made to ensure that the Assembly at its next session would have a full and comprehensive report and a useful discussion on measures that could be taken to improve the situation.

Dr BRITO GOMES (Cape Verde) said that, although his country had a high annual population growth rate of 3%, a birth rate of 35 per 1000 and a fertility rate of 4.5 per 1000 and very scant resources, it had succeeded over the past ten years in reducing its infant mortality and increasing life expectancy. Maternal and child health was one of its primary concerns, and special stress was laid on family planning, in view of Cape Verde's position as a country in demographic transition. His delegation considered that programme 9.1 deserved particular attention because of its importance for the socioeconomic development of the populations of developing countries and its impact on their nutrition, education, health and employment.

Dr WILLIAMS (Sierre Leone) said that, whereas many years previously the Planned Parenthood Association of Sierre Leone had been the only body providing family planning services in the country, there were now no less than eight organizations independently supplying such services, with the result that the programmes overlapped in some communities and were totally neglected in others. Moreover, the programmes were funded mainly by one or two Great Powers, which were pouring large amounts of money into them for the sole reason that they related to family planning, to the neglect of other components of maternal and child health services; consequently some communities were confused by the contradictory messages they received from different directions. As Chief Medical Officer of her country,
she had tried unsuccessfully to integrate those family planning programmes and now requested WHO to provide the services of a short-term consultant to help with the integration of the programmes with each other and into the overall maternal and child health services. In addition, that consultant might give the authorities assistance and guidance in the vital area of educating young people and adolescents in fertility and health, including sexually transmitted diseases; her Government would be pleased to participate in any action-research programmes to guide adolescents themselves towards taking part in measures designed to improve their overall health and their socioeconomic status in the country.

With regard to the Expanded Programme on Immunization, her country's activities were unfortunately not proceeding very satisfactorily, and she appealed to WHO and UNICEF and other organizations, such as Rotary International which were providing the vehicles, cold chains and vaccines for the programme, to review their policy under which the country had to provide petrol for vehicles and kerosene for refrigerators at health centres, since the inability of the national authorities to provide the fuel sometimes brought the programme to a complete standstill. She therefore requested WHO to provide the necessary funds and experts for an evaluation of her country's programme, in the hope that there might emerge a recommendation for a change in that policy.

Dr LIU Xirong (China) said that his delegation supported programme 9.2 (Human reproduction research). WHO was to be congratulated on the success of its activities in that regard and on the support it was giving to developing countries in the establishment of family planning research institutions and application of new technologies. It was gratifying to note that collaboration between WHO and China in that area had developed rapidly in recent years and that the prospects for future cooperation were widening. Chinese experts were currently actively involved in research relating to oral, injectable and hormonal contraceptives, IUDs, female sterilization and other methods of fertility control. China's research activities had already yielded excellent results in some areas and positive achievements were expected in others in the near future; his country was prepared to share the results of its research with other Member States.

With a view to promoting the success of the programme, his delegation wished to suggest: first of all, that WHO should pursue its efforts to help developing countries to enhance the quality of family planning research by strengthening the training of research personnel; secondly, that the Organization should help to establish collaborative family planning research centres and should intensify the use of existing centres.

Dr MGENI (United Republic of Tanzania) expressed his delegation's support for programme 9.3 (Workers' health), in view of the disturbing current trends in the health of working populations throughout the world. The health problems affecting a cross-section of different occupations, geographical regions and socioeconomic situations, and recent concern over the specific problems of women workers called for the provision of overall health care at various levels and in different aspects of health delivery. Whereas until recently attention had been paid to specific occupational diseases, new dimensions had been added in connection with what were now known as work-related diseases — conditions closely associated with negative psychosocial factors, life-styles and attitudes to work and life, apart from poor environmental working conditions as such. In view of that complex of interacting factors, the rational approach was not necessarily to focus mainly on large industrial and commercial institutions or agricultural enterprises: the health care needs of large working populations engaged in small-scale industry and farming could be met through primary health care strategies, especially in developing countries. The main objective of those strategies was to educate the workers in an awareness of the problems confronting them and of the measures that they themselves could take to alleviate them by preventive action, while the various levels of health care responded accordingly. That was why his delegation welcomed the provision in the proposed programme budget for promoting workers' health education. It would also appreciate further strengthening of technical, planning and managerial capabilities at the Regional Office for Africa, so that Member countries could be advised on establishing the correct priorities and developing their programmes for the promotion of occupational health more objectively in the light of their socioeconomic situations. In view of the increasing need to contain the expanding dimensions of occupational health problems, his delegation urged Member States to adopt a resolution in favour of more aggressive promotion of workers' health, which should not be underestimated if the working populations were to be led successfully towards the goal of health for all.

Dr GEORGIEVSKI (Yugoslavia) said that, in the area of maternal and child health (programme 9.1), no section of the population needed greater protection than infants. It was well known that breast-feeding was the best way to protect infants against gastroenteritis,
respiratory diseases and diarrhoea, as well as malnutrition. Between 75% and 80% of mothers in Yugoslavia breast-fed, which was encouraged through primary health care and hospital practices conducive to natural feeding, paid maternity leave and the prohibition of advertising of breast-milk substitutes. His country had been assisted in that policy by the International Code of Marketing of Breast-milk Substitutes, adopted by the Health Assembly in 1981. Parts of the Code had been incorporated in a Federal resolution on health care priorities and methods, which the Federal Assembly of Yugoslavia had adopted in 1983. He supported speakers who had called for study and clarification of certain sections of the Code, particularly with regard to free supplies of breast-milk substitutes, and endorsed the proposal that had been made for a meeting or study group on the subject to be held during the current year, so that the Director-General could report on it at the next Assembly.

Dr TIRA (Kiribati) said that his delegation also supported programme 9.1 (Maternal and child health, including family planning), and wished to record its appreciation of the importance attached to those problems as reflected in the allocation from the regular budget and the assurance of extrabudgetary funds from other sources. While it appreciated the great efforts made by WHO to promote maternal and child health, it saw with concern that the magnitude of the problem was not declining despite those efforts: was that because new problems were arising or because the strategies were wrong? The problem of early use of milk substitutes had arisen in Kiribati, especially among young mothers. In that connection, his delegation was grateful for the efforts made by WHO and other agencies to encourage breast-feeding as an essential component of child health care. With regard to the International Code of Marketing of Breast-milk Substitutes, his delegation would be glad if Member States would adhere to the clauses of that Code and prohibit the use on those products of pictures of healthy babies, which held great appeal for the young mothers of his country.

Professor INDULSKI (Poland) supported the view of the Director-General that the health of the working population was important for the achievement of health for all (programme 9.3, paragraph 3). Indeed, it was hard to imagine that the health of the working class—in Poland acknowledged to be the political leaders—might be excluded from health for all. The increased budget allocation for the worker's health programme was fully justified and deserved support.

The activities of the Office of Occupational Health at headquarters had provided a sound basis for the strengthening of workers' health programmes at both the international and national levels. Studies had been initiated and the latest information had been disseminated, permitting many countries to rationalize their workers' health care. Most of the solutions were based on appropriate technology, the implementation of which was not beyond the financial means of even the less affluent countries. Improvements in diagnostic methods were permitting the early detection of health impairment in workers and results of epidemiological studies permitted concentration of efforts on priority health problems.

The foundation of the occupational health service in Poland in 1953 had been justified on both political and health grounds. Poland took pride in the fact that the service now covered six million workers, i.e., almost 60% of those employed, with 100% coverage in such sectors as mining and metallurgy, 80% in the chemical industry, 75% in construction and over 70% in light industry. The industrial health service employed more than 8500 physicians, 3500 dentists and 10 000 nurses as well as other qualified personnel; there were four specialized national research institutes of occupational health. The occupational health services were an integral part of the health care system and occupational health physicians, who provided a full range of preventive and curative services in addition to supervising the working environment, were paid exclusively from the health service budget, thus remaining fully independent of the industrial administration. The occupational health services had effectively solved a number of problems that were now being faced by other countries, and had done so despite the difficult economic situation in recent years.

Yet a number of problems remained, in particular that of effective utilization of resources. Considerable resources were devoted to the occupational health services, but there was reason to believe that not all of them were used in the most effective way. In that connection he welcomed the emphasis given to basing workers' health care on primary health care at the workplace, a direction that should be supported.

He also supported the Director-General's proposals regarding the development and strengthening of the network of WHO collaborating centres (paragraph 14). The preparation of guidelines for the monitoring of the environment and its health effects (paragraph 13) was a promising prospect. The past and planned activities of WHO and its collaborating centres permitted the hope that the problems of workers' health would one day be solved successfully.

In conclusion he would like more information about programme implementation at the regional and national levels, and, in particular, about how primary health care was accommodating workers' health.
Dr REGMI (Nepal) said that many developing countries, including his own, were engaged in various campaigns to prevent birth control activities. In his opinion, maternal and child health should be given top priority rather than family planning alone. Maternal and child health, which formed the core of the primary health care programme, was one of WHO's most important activities and was closely linked to health-for-all strategies. Women and children constituted the majority of the world's population and were the most important members of the family, so that every effort should be made for their protection. Malnutrition, acute respiratory infections, diarrhoeal diseases, and other communicable diseases were some of the many hurdles faced by the infant. They were hurdles faced by governments too in trying to solve health problems. Maternal and child health programmes were essential to the acceptance by the community of family planning and so to its success and with it the success of population programmes. Financial and technical resources from all quarters, bilateral and multilateral, should be channelled into maternal and child health programmes rather than directly into family planning alone. He welcomed WHO's action in that area, which was most timely.

Dr BRÄMÉR (German Democratic Republic) said that in his country great importance was attached to workers' health and to strengthening occupational health services. His delegation therefore agreed with the challenging target set for programme 9.3, which was to foster national and international action so that by 1989 50% of Member States would have developed occupational health programmes.

The situation analysis on pages 137 and 138 of the proposed programme budget failed to show that the limitations and constraints described did not apply equally to all countries. For example, in the German Democratic Republic the protection of workers' health was the concern of society and the responsibility of the State, so that it was given comprehensive support. In the preparation of future programme budgets, the situation analysis should contrast the levels of occupational health care reached in different countries. The German Democratic Republic would continue to support programme 9.3 and was ready to share its experience, especially in research and training, with WHO and through it, with other countries, particularly those in Africa, Latin America and South-East Asia. He stressed that occupational health services should be integrated with primary health care, especially in predominantly agricultural areas. His country would be interested in discussions on that aspect.

Dr BROTO WASISTO (Indonesia) agreed with previous speakers that maternal and child health was an important programme and an element of primary health care. His delegation supported the integration of maternal and child health programmes with other activities such as, immunization, diarrhoeal disease control, and nutrition. In his country maternal and child health had been integrated with other programmes some two years previously, as part of a family health package. Such integration, particularly at operational levels, was improving cost-effectiveness in the reduction of the mortality of infants and under-fives, which was one of the health status indicators for monitoring progress towards health for all. He welcomed the strong technical support for those efforts that had been given by WHO headquarters and the Regional Office. There was now a need to improve the management of activities in the integrated programmes, which was no easy task. His delegation suggested that the international agencies provide more technical assistance for management of integrated programmes at all levels of administration in Member States.

Dr QUÆBÉIN (Jordan) said his Government gave priority to maternal and child health, with a special centralized division undertaking the supervision and evaluation of services delivered over the whole country. The supervision took account of the quality and coverage of services, and on the basis of the evaluation appropriate amendments to the strategies were made. Communities participated by providing buildings to accommodate services and by sending women to study midwifery, who then returned to work in their own villages. Midwives and nurses visited pregnant women and sick children to give advice, and women in need of hospital deliveries were thus identified and referred. During their visits to maternal and child health centres women received health education through group discussions, films and demonstrations on subjects such as nutrition and immunization.

Maternal and child health services were closely coordinated with the expanded immunization programme and the diarrhoeal disease control programme, and all those services came under the primary health care directorate. In the field of diarrhoeal disease control the main emphasis was on oral rehydration therapy, with centres providing training in its techniques. No advertising of breast-milk substitutes was permitted.

Activities in the field of occupational health were also carried out through the directorate of primary health care and took place both inside factories and in the neighbouring environment. Lead poisoning had been reduced in workers in battery factories as
a result of surveillance and the monitoring of lead levels in the blood and urine of workers, followed by corrective measures. The survey had been supported by the Government and by nongovernmental organizations in cooperation with the University of Jordan. Considerable support had been received from WHO for the study and for other activities in the field of worker's health. All factories were visited by physicians with a qualification in occupational and industrial health, and workers were provided with the necessary protective measures and equipment. Special attention was given to food factories. The aim was to have specialists in occupational health in all five governorates in Jordan; they were currently provided for three governorates.

In Jordan the elderly were cared for by their families. In his opinion that was the right way: the elderly were stabilized emotionally and the children learned to care for their elderly relatives. It was better for elderly people to stay with their families or in their own homes and to be provided with help and support there. Old people's homes could be a sad experience, with occupants receiving few visits from their relatives. In the absence of families, a system of individual accommodation for the elderly linked by a communicating bell or light system, together with support regarding food, etc., which he had seen in operation in the United Kingdom, was worthy of study.

While Jordan had not yet achieved health for all, it had taken many steps along the way.

Dr KLIVAROVA (Czechoslovakia) said her delegation supported programme 9.
Czechoslovakia considered considerable priority to maternal and child health, as an integral part of State health policies and primary health care. Her delegation therefore supported programme 9.1, and welcomed its incorporation into primary health care. In her country physicians, gynaecologists, paediatricians and nurses were all involved in the care of women and children, and the system had led to a substantial decrease in infant mortality and to the eradication of measles and poliomyelitis as well as the elimination of diphtheria and whooping cough. Immunization against parotitis, and against rubella (for girls) was currently being undertaken. Czechoslovakia wished to participate actively in programme 9.1.

Her delegation welcomed the orientation of programme 9.4 (Health of the elderly) towards primary health care. In Czechoslovakia medical and social care of the elderly was organized by nurses specialized in geriatrics under the supervision of district physicians. The elderly were encouraged to continue an active life with their families or in their own homes. There were many clubs for the elderly, especially in towns, which organized social and cultural activities. The social insurance system provided services for the disabled for meals and domestic cleaning. There was also a system of homes for the elderly, where they had their own rooms and their own furniture. They were fully cared for, with easy access to medical services. There was also a system of special care for the chronically ill in centres which were increasing in number annually.

Dr QUAMINA (Trinidad and Tobago) said that her delegation had noted with approval the increase of 9.66% in real terms in the allocations for programme 9.1 (Maternal and child health, including family planning). The fact that the increase had been reflected in larger allocations to country programmes was most satisfactory. Although due attention had to be paid to newer issues, such as the care of the elderly and health of workers, the impetus of the more traditional programmes such as maternal and child health should not be lost. Some headway had been made - for example the improved literacy rates for women had contributed to reducing infant mortality; but solutions to the problem of perinatal mortality were more complex and required not only the education of mothers on child spacing and sound nutritional practices, but also the collaboration of hospital-based obstetricians and paediatricians.

As a result of improved prenatal care at primary health care levels, greater demands were being made on secondary and tertiary level hospitals. There was a need for some clear evaluation of the efficacy of the new diagnostic screening procedures and guidelines for their rational use, since they might be diverting resources from other important aspects of the maternal and child care programme. In Trinidad and Tobago a study of the factors relating to perinatal mortality was planned with a view to achieving the most effective use of the limited resources available.

In spite of extensive family life education programmes, the number of teenage pregnancies had not fallen. It was vital to provide opportunities for adolescents to discuss health and family problems with trained health and social workers as a means not only of improving maternal and child health but also of reducing the prevalence of sexually transmitted diseases and assisting young people to deal with the psychological stresses caused by a lack of appropriate employment opportunities.

The authorities in Trinidad and Tobago were continuing to monitor application of the International Code of Marketing of Breast-milk Substitutes and the private health sector was also actively encouraging breast-feeding. The need for many mothers to return to work within three months after delivery was the main reason given for introducing bottle feeding so soon.
In connection with workers' health (programme 9.3), a laboratory had recently been established and was being equipped with the assistance of EEC funding in order to provide the required technology for monitoring health hazards in the work environment.

Dr SAVEL'EV (Union of Soviet Socialist Republics) said that programme 9.1 (Maternal and child health including family planning) was one of the most important programmes directly related to the development of primary health care; the measures envisaged in the 1986-1987 proposed programme merited full support, especially the emphasis placed on research and on the evaluation of the efficacy and acceptability of existing technology, particularly in developing countries. In programme 9.2 (Human reproduction research) greater emphasis should be placed on the problem of infertility, which was serious in many developed countries.

He supported the remarks of the delegate of the German Democratic Republic concerning the programme 9.3 (Workers' health) which covered a wide range of aspects of the prevention and treatment of workers' diseases. His delegation supported the proposals for research on various important problems including the study of the long-term effects on health of exposure to harmful physical and chemical factors at low levels. Considerable attention was rightly given to inclusion within the primary health care services of measures to protect workers' health. It was rightly pointed out in paragraph 9 of the programme statement that the principal problems related to workers' health to be dealt with at country level included not only technical matters but also political and socioeconomic issues; the experience and achievements of the USSR in the field of occupational health fully confirmed that statement. The USSR was ready to share that experience with WHO and any interested Member State. WHO should work out a specific definition of work-related diseases; otherwise almost any form of disease to which workers were subject during their working life could be included in that category.

Regarding programme 9.4 (Health of the elderly), his delegation supported the elaboration of national programmes including the development of special medical and social services to cover the specific needs of the elderly. Particular attention was paid in the USSR to determining those specific needs and to finding ways of meeting them. Special surveys were being carried out at the Institute of Gerontology of the Academy of Medical Sciences of the USSR and in other institutions with a view to preparing recommendations aimed at further improving services for the elderly. Research was also being carried out with the participation of the Academy of Medical Sciences of the USSR and other institutions, to clarify the mechanism of aging, increase life expectancy and prolong active life.

Professor DAVIES (Israel) supported programmes 9.1, 9.2 and 9.3 as presented, but would welcome information on the further use of the risk approach in maternal and child health.

His delegation regarded programme 9.4 (Health of the elderly), as the archetype of the way WHO should work. The budget was small and the staff microscopic, but by attracting cooperation and resources from all over the world and by successful coordination of the work of nongovernmental organizations the programme had been able to cover a wide spectrum of activities, including molecular biology of the aging cell, preventive measures and the provision of health care, including self-help care, the enormous social, economic and medical problems of supporting the growing elderly populations, and ways of adding health, dignity and quality of life to advancing years. He was pleased to announce that the Association of Schools of Public Health of the European Region would be considering at its next meeting the role of schools of public health in preparing manpower for an aging society.

It was however important to remember that the majority of the aged in the world were in the developing countries, and that population would reach the 60% level by the year 2000. The rapid social changes which had occurred in many countries highlighted the needs of those who traditionally had been cared for by their families and tribes. If "health for all" had any real meaning, it had to include all sections of the population, including the increasing proportion of over sixty-fives; the very low budget appropriations for some regions and countries, especially those of Africa, was a matter of serious concern. His delegation believed the programme to be underbudgeted, and urged the Director-General and the Executive Board to explore ways of strengthening it.

Mrs TAGWIREYI (Zimbabwe) said that her country had not yet been able to assess the magnitude of the problem of maternal undernutrition, which undoubtedly contributed significantly to the poor nutritional status of young infants. It would welcome WHO's guidance on appropriate and simple indicators for the regular monitoring of maternal nutritional status. Great efforts had been made in Zimbabwe to promote breast-feeding as an essential element in maternal and child health. A study had been made of the marketing practices of some infant food companies and a national code had been prepared for Zimbabwe, dealing not only with the promotion of breast-feeding but also with the quality of weaning.
foods, since it was believed that the most serious nutritional problems originated during the weaning period. Although the International Code of Marketing of Breast-milk Substitutes provided a sound guideline, there was one aspect which was still open to abuse and misinterpretation, namely the statements to the effect that a small minority of infants would still "need" breast-milk substitutes. It was often not clear what constituted a real "need". In countries such as Zimbabwe, where scarce foreign exchange had to be allocated for the import of some of the raw ingredients necessary for the manufacture of breast-milk substitutes, it was most important to define clearly the proportion of infants actually needing them. She hoped that WHO would collaborate with Member States and other relevant agencies in developing appropriate criteria or guidelines concerning infants needing breast-milk substitutes.

She noted that guidelines were to be prepared in the European Region for the organization of school health services (paragraph 21 of the statement for programme 9.1) and hoped that they might be applicable in the African Region also.

Dr UNSAL (Turkey) said that his delegation fully supported programme 9.1. Infant and maternal mortality was still high in Turkey in spite of the country's rapid development. After several meetings, workshops and seminars held in 1984 and 1985 with the participation of governmental and nongovernmental sectors and international organizations, the Ministry of Health and Social Assistance had decided to accelerate the immunization and family planning programmes, with the aim of reducing the infant mortality rate by 50% during the next five-year period. The accelerated immunization programme would begin in September 1985, and 4.5 million children were expected to be immunized against measles, diphtheria, pertussis and tetanus, and poliomyelitis. The main elements of the national programme would be the strengthening of the primary health care infrastructure, cold-chain facilities, training of health personnel, and health education; great emphasis would be placed on multisectoral collaboration and community participation, as well as on the establishment of qualified and effective planning, monitoring, and evaluation procedures. Family planning was being taught as a main strategy for protecting the health of mothers, the family and the community. Training programmes in that area for community leaders had already started, and health education programmes were being implemented with the collaboration of various governmental bodies and nongovernmental organizations.

He supported previous speakers who had emphasized the importance of breast-feeding for child health. He hoped that the problem of mothers working away from home would be solved when the economic impediments were removed.

Mr BALAKRISHNAN (India) expressed support for programme 9 - and, in particular, programmes 9.1 and 9.2, which brought out very clearly how much had to be done with limited resources. In regard to paragraph 5 of the statement for programme 9.1, he shared the concern of other delegations that, in spite of the adoption of various policies and programmes, the practice of breast-feeding was starting to decline in rural areas in the developing countries. His delegation fully endorsed the statement in paragraph 10 that the role and status of women were extremely important in promoting maternal and child health, and he was most interested in the proposal in paragraph 20 to hold an interregional meeting on technologies relating to the prevention and control of neonatal tetanus and puerperal and neonatal sepsis - major factors in infant mortality.

Turning to the question of human reproduction research (programme 9.2), he said that fertility control was central to population stabilization, an aspect which had been given high priority in the Indian national health effort; he commended the work of WHO, especially its efforts to find new donors and increase funding for the human reproduction programme. He saw no reason why a choice had to be made between maternal and child health and fertility control. Both programmes should be pursued in an integrated and coordinated fashion. Development efforts in many countries would be completely negated in the absence of fertility control and population stabilization measures.

Dr ADANDE-MENEST (Gabon) expressed his country's continuing support for the Special Programme on Research, Development and Research Training in Human Reproduction, which demonstrated WHO's awareness of the problems of the Third World regarding fertility regulation. Certain Third World countries were aware of the importance of the programme for their overall development and wished to take an active part in promoting human reproduction research - for instance the Franceville International Centre for Medical Research (CIRMF) bringing together researchers from Africa and elsewhere for work on human reproduction, had been set up in Gabon in 1979, and had later become a WHO collaborating centre. Yet despite all the work done the Special Programme was still funded mainly from extrabudgetary resources. While approving the activities provided for under programme 9.2, he wished to appeal to the
organizations already taking part in it, as well as to potential donors, to increase the funds allocated to it, and requested WHO to increase its regular budget allocations to the extent possible, particularly for the treatment of infertility.

Professor SENAULT (France), expressing his appreciation of programme 9 as a whole, wished to draw attention to the question of adolescent health, which was particularly important in view of its socioeconomic implications and the need to adopt a comprehensive approach to the health of the individual throughout life, rather than to "segment" the adolescent as was sometimes the case. One particular problem concerning adolescent health today in countries undergoing social and economic difficulties was the prevalence of drug, alcohol and tobacco abuse among young people awaiting their first job, and he wished to know whether that problem had been taken into account in programme 9.1.

His delegation was pleased to note that WHO would promote and support the dissemination and exchange of information on adolescent health.

Dr OTTOO (Ghana) expressed his delegation's support of the programme activities proposed under nutrition (programme 8.1) and under maternal and child health (programme 9.1). He regretted, however, the absence of emphasis on national nutrition policies; without such policies, the other activities under programme 8.1 could not achieve the long-term objective of solving nutrition problems in developing countries. Emphasis should therefore be placed on strengthening national capabilities to formulate and strengthen such policies as a basis for intersectoral programmes within the primary health care system. He urged the Director-General to provide direct WHO support, in cooperation with FAO, to developing countries for that purpose.

Mrs RASHIDI (Malawi) said that her country gave high priority to programme 9 and supported the proposed activities.

She joined other delegates in proposing that the Director-General convene a meeting to clarify Articles 5.2, 6.6, 6.7 and 7.4 of the International Code of Marketing of Breast-milk Substitutes. It was important for the Code to be clear and widely known if it was to be observed both by Member States and by the companies marketing those products. She hoped that the costs inherent in her suggestion could be met by additional voluntary contributions. Donations of free milk by breast-milk substitute companies were detrimental to breast-feeding and should be halted.

Professor FORGACS (Hungary) expressed support for the objective and targets under programme 9.4 (Health of the elderly). They were similar to those adopted in his own country, which was prepared to participate in that programme.

His country had tackled the problem of an aging population by setting up a national committee on the subject. Care of the elderly came under primary health care, including the provision of social services, which was less expensive and more humanitarian than placing them in institutions. Efforts were also made to involve them in the promotion of their own health and the maintenance of their social status. Families, communities and self-help groups were all involved in the psychosomatic and social care of the elderly.

Dr GRECH (Malta) welcomed the importance given to the health care of the elderly (programme 9.4). There was a growing awareness of the medical, economic and social problems posed by an aging population even in the developing world.

His delegation also supported programme 9.3 (Workers' health) and trusted that WHO and ILO would continue to work together through the inter-agency coordinating committee.

In those as in other fields, needs were best met in the context of the family and the community, the medical practitioner being the leader of a multidisciplinary team working in the primary health care services. However, while programme 9 as a whole was commendable, not enough emphasis had been laid on the reorientation of the undergraduate teaching of doctors, which in many countries was still too strictly geared to curative medicine to the exclusion of the wider context.

Dr TRAORE (Mali), referring to programme 9.1 (Maternal and child health, including family planning), and more specifically to the problem of excessive maternal mortality in certain poor countries, said that maternal mortality was often caused by childbirth complications. In Mali, where there was a shortage of qualified midwives and medical practitioners specializing in gynaecology and obstetrics, efforts had been concentrated on teaching traditional birth attendants to recognize the major complications of childbirth and to refer them to the appropriate health care facilities in time, and to provide adequate prenatal and postnatal care. Experience had shown that such auxiliary health workers could
contribute to a reduction in maternal mortality, provided that the supporting health care facilities were strengthened, he would be interested to hear the opinion of WHO on the subject. Countries with a shortage of qualified medical personnel might benefit from Mali's experience.

Professor KAKITAHI (Uganda) expressed appreciation of the efforts made in programme 9 to address the question of the health of women and children, the most vulnerable groups of the population. Since maternal and child health, themselves interrelated, were bound up with the family and the community, he supported the delivery of maternal and child care services, including family planning, through primary health care.

A matter of particular concern was the growing number of adolescent mothers, who were malnourished and consequently unable to breast-feed their infants successfully. His delegation requested WHO to assist countries, mainly developing countries, to develop local weaning foods at the country and regional levels.

A two-week seminar for breast-feeding counsellors was currently being held, in collaboration with the International Baby Food Action Network, in his country with a view to supporting and improving child nutrition through encouragement of breast-feeding.

While he noted that there had been some improvement in the observance of certain aspects of the International Code of Marketing of Breast-milk Substitutes, he joined other speakers in asking the Director-General to have certain points studied and clarified, in particular the matter of donations of breast-milk substitutes, and to report to the Health Assembly in 1986.

In regard to workers' health (programme 9.3) he drew attention to the fact that women - who in Africa accounted for 90% of agricultural workers - were a particularly vulnerable group, and should be included among those for whom control of occupational health hazards was needed.

The meeting rose at 17h35.
SEVENTH MEETING
Tuesday, 14 May 1985, at 9h00
Chairman: Dr J. VAN LONDEN (Netherlands)

1. FIRST REPORT OF COMMITTEE A (Document A38/31)

The CHAIRMAN read out the draft first report of the Committee.

The report was adopted (see document WHA38/1985/REC/2).

2. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1986-1987: Item 22 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II) (continued)

PROGRAMME POLICY MATTERS: Item 22.2 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II, Chapter II) (continued)

Health science and technology - health promotion and care (Appropriation Section 3; Documents PB/86-87, pages 106-199; EB75/1985/REC/1, Part II, Chapter II, paragraphs 37-56; A38/INF.DOC./3; A38/INF.DOC./4; A38/INF.DOC./7; and A38/INF.DOC./11) (continued)

Protection and promotion of the health of specific population groups (programme 9) (continued)

Dr MAGNUSSON (Iceland), speaking on programme 9.4 (Health of the elderly), welcomed the increase in budget allocations for that programme, which emphasized the integration of health services for the elderly within primary health care, self-help, information and education. The elderly needed to be actively involved in running the community services which affected them. The apparent discrepancy between subjective and objective assessments of the health status of the elderly could lead to excessive institutionalization; more research was needed into factors which helped the elderly to remain in their families and communities.

Dr ASSELIN (Canada), referring to maternal and child health, including family planning (programme 9.1), echoed the hope expressed by the delegate of Swaziland and by other delegates that the International Code of Marketing of Breast-milk Substitutes would be a useful and effective instrument. Any ambiguities in connection with Article 6.6 of the Code should be clarified without delay; his delegation agreed that a working group should be convened to that end, with the participation of UNICEF.

His delegation supported programme 9.4 (Health of the elderly) but wished to emphasize that the achievement of a high life expectancy at birth did not solve all problems. For example, in Quebec in 1980 life expectancy at birth had been 78 years for women and 70 years for men. However, life expectancy in good health was only 60 years and 59 years respectively. The goal of health for all was thus not necessarily achieved merely by adding years to the lives of the elderly.

A study conducted in Quebec had shown that loss of support from family and friends led to a 34% increase in requests for places in institutions and a 116% increase in requests for places elsewhere. Those who helped the elderly to remain in the community therefore needed help and support, and nongovernmental organizations could play a major role in that regard. From what the delegate of Kuwait had said at the fourth meeting, it seemed that the problem at present affected developed more than developing countries.

Dr BATCHVAROVA (Bulgaria), speaking on programme 9.1 (Maternal and child health, including family planning), said that that programme would have to be given top priority if the high maternal and infant mortality in many countries were to be reduced. The programme...
rightly emphasized the need for coordination between national and international organizations and institutions, and the need for a mobilization of effort, with other related programmes, such as immunization, diarrhoeal diseases and nutrition, since a comprehensive approach to the problem was essential. Congenital and hereditary diseases had caused increasing concern in recent years, so that early perinatal and postnatal diagnosis and treatment were necessary. In view of the seriousness of such diseases, her delegation proposed that they should be included in the programme, if possible. Investigations carried out by the Academy of Medicine of the People's Republic of Bulgaria had shown a high incidence of hypertension in young people. In view of the social and medical significance of juvenile hypertension and the tendency for it to develop into arteriosclerosis, it seemed advisable to include in the programme studies of its pathogenesis, prophylaxis, treatment, genetic aspects, etc. Her delegation welcomed the proposal made by the delegations of Swaziland, Zimbabwe, Qatar and Yugoslavia that a WHO working group should be set up to establish criteria for the use of breast-milk substitutes. Her country had a great deal of experience in problems of child growth and development, together with research facilities, and was willing to share its experience with WHO and its collaborating centres.

Turning to programme 9.3 (Workers' health), she said that it covered the priority issues affecting both developed and developing countries. Her delegation considered, however, that more emphasis should be placed in paragraph 8 of the programme statement on the need for research into new risk factors, such as computers, visual display units and micro-electronic devices. Such research was essential in order to avoid a repetition of the adverse effects which had been experienced during the mechanization of industry.

Her delegation also considered that more emphasis should be placed in paragraph 12 on the occupational health of women workers. The industrialization of the developing countries inevitably resulted in the employment of many women in factories, but the programme statement referred only to vulnerable working populations; female workers should be specifically cited. Her country would continue its active cooperation with WHO in the programme.

Programme 9.4 (Health of the elderly) was very important at the present time, both because of the increasing proportion of elderly people in the population and because the health-for-all strategy required that the elderly should be guaranteed not only good mental and physical health but also an active social attitude to life. It was important to coordinate the programme with the health education and nutrition programmes, given the importance of life-styles, physical training and proper food in the prevention of premature senility, cardiovascular disease, etc. Her country had a great deal of experience in providing gerontological care to the population, including social welfare, and would be willing to participate in international research or organize scientific conferences. The Academy of Medicine was carrying out two long-term studies, one on the mental health of the rural population and the other on the effect of exercise on the ageing process, and would be willing to share the interesting results obtained with Member States.

Dr MIGUES (Uruguay) said that his delegation supported the maternal and child health programme, particularly in view of the unusual demographic changes, resembling those in the developed countries, which had taken place in his country. Both birth and death rates had fallen, the total fertility rate was 2.8 in 1979-1981, and the population was increasing by only 0.5% per annum, with a tendency for the proportion of the elderly to increase. Those over 65 constituted 14% of the total population. As a result, the health of the mere 55 000 children born annually in Uruguay was a matter of great concern. A recent study carried out in collaboration with PAHO and UNDP had concluded that certain groups of the mother and child population deserved particular attention. Pregnancies were most frequent in the low-income groups; child-bearing being spread over a longer period, mothers were often very young or comparatively old, and the intervals between pregnancies were short. The perinatal death rate was 59% higher among illegitimate than among legitimate children because of the high proportion of unmarried mothers, the lack of adequate education and supervision, especially in the interior of the country, etc. His delegation was particularly interested in the activities mentioned in paragraph 25 of the programme statement, especially with regard to action studies of the measures aimed at preventing infertility through primary health care and the review of available information on the epidemiology and etiology of infertility. Research was currently being conducted in his country into the direct and indirect causes of the decline in the fertility rate; the results would be passed on to other countries in a similar situation.

Dr MOHITH (Mauritius), referring to the programme on maternal and child health and to paragraph 5 of the programme statement, in particular, agreed that the decline in breast-feeding gave serious cause for concern. It was essential to discover the reasons behind it; economic and social factors might be involved. His delegation welcomed the
proposal made by the delegate of Swaziland and endorsed by the delegate of Canada that a working group should be set up to conduct an in-depth analysis of the problem.

Mr PUNA (Cook Islands), speaking on programme 9.4 (Health of the elderly), said that the WHO approach to the health care of the elderly was cost-effective and met the needs of elderly people. He was proud to say that in his country there were no institutions for the elderly; they were not removed from their immediate or extended family because of age or minor ailments, and their irreplaceable role in the family unit was respected in his country, as in many other countries of the Western Pacific Region. His delegation welcomed the WHO training programmes for health employees responsible for the elderly, since such training might easily be overlooked in developing countries.

Dr FERNANDO (Sri Lanka) said that the maternal and child health programme was a cornerstone of primary health care. His country had emphasized maternal and child health since the 1930s and that emphasis, together with the high rate of literacy among women, had created a satisfactory situation for a developing country. Maternal and child health should always be given its due place in primary health care. His country had attempted to improve the environment in order to reduce diarrhoeal diseases and had passed new food laws. The use of oral rehydration salts in the field and in hospitals had reduced deaths from such diseases.

The birth rate had been reduced to 28 per 1000, with voluntary sterilization proving more popular than temporary methods of contraception. Life expectancy had increased, but health services to the elderly had not been expanded and his country would welcome the assistance of WHO in that area.

Dr EL BERNawy (Egypt) supported programme 9.1 (Maternal and child health, including family planning) as a whole. However, when comparing the 1984-1985 and 1986-1987 programme budgets for the African and Eastern Mediterranean Regions, his delegation noted that allocations for the programme from the regular budget had increased by some US$ 450 000, but those from other sources had decreased by some US$ 2.75 million, a reduction of more than 27%. Since both those Regions needed more support in the field of maternal and child health and family planning, his delegation would like those allocations to be reconsidered.

Egypt accorded high priority to the programme and had built up an extensive network of rural health units reaching to the remotest areas. All of them provided maternal and child health care as a free service. Each unit was headed by a fully qualified physician and staffed by two assistant nurses. Traditional birth attendants were again recognized and were being trained and licensed to practise home deliveries under the supervision and control of the health units.

As regards family planning, Egypt had always adopted the health approach. Family planning services had been provided for some 20 years as an integral part of basic health services. As a result, the crude birth rate had decreased from 43 per 1000 in the early 1960s to 36.8 per 1000 in 1984, and the total fertility rate had decreased from 7 to 5.2.

Egypt had just established a National Population Council, chaired by the President of the Republic, whose members consisted of the Ministers of Health, Education, Social Affairs and Planning. The Council would thus give a stronger political impetus to the family planning programme. Its scope included family planning, the improvement of child care so as to reduce the infant mortality rate, the improvement of the wellbeing and sociocultural status of women, together with a nationwide literacy programme.

His delegation would like to see a strengthening of research efforts and capabilities in the study of the safety and efficacy of different contraceptives, especially of steroids, and of long-acting ones in particular. It was important not to endanger the health of women and children by using contraceptives whose future effects were unknown, especially in Third World countries where experiments in the use of long-acting contraceptives were taking place.

Mrs ODVORI (Kenya) said that her delegation supported the proposed programmes 9.1 to 9.4 and held similar views to those expressed by the previous speakers.

She had a few comments to make on the subject of women, health and development. Women constituted slightly over half of mankind. They tended children, who made up a large proportion of the population, produced food, prepared meals and were of critical importance for the welfare of the family and of society as a whole. They were able and prepared to contribute more, but must be given the opportunity and support to do so. Where women had been given such support, excellent results had been achieved within a short time. She therefore called on all Member States, when planning and implementing their strategies for health for all, to remember to support the women in that endeavour.
In that connection, an important conference was due to take place at Nairobi in July of the current year when the United Nations Decade for Women would be reviewed. WHO would be represented and she hoped that many participants in the Health Assembly would also be there. She hoped that the conference could be used to marshal additional support for women in the achievement of the goal of health for all by the year 2000.

Mr FEKIH (Tunisia) said that his country had been implementing a population and family planning policy for some 30 years, with appropriate legislation and a national programme providing services accessible to all. Special efforts had been made to educate the population in family planning in schools, health centres, and industrial and agricultural enterprises. Family planning services were provided in health centres and complemented maternal and child health services. Those programmes had received international assistance from governments and had also been helped by WHO and UNICEF.

Vaccination against tuberculosis, diphtheria, tetanus, poliomyelitis and measles had been made compulsory for all children. Emphasis had been placed on the training of personnel and educating the population and, as a result, the infant mortality rate had fallen to about 70 per 1000.

Tunisia was implementing the WHO recommendations on the marketing of breast-milk substitutes and had introduced appropriate legislation, and breast-feeding was being actively encouraged.

Workers' health was receiving particular attention, legislation having been introduced, together with preventive and therapeutic measures, the activities being coordinated by the Institute of Occupational Health. All those activities were aimed at achieving health for all by the year 2000.

Dr TEJADA-DE-RIVERO (Assistant Director-General), referring to questions raised about the fact that the allocations for some programmes from the regular budget were small in relation to the extrabudgetary sources indicated, said that that was one of the characteristics of the so-called "special" programmes, which included others besides the human reproduction research programme. Another characteristic of those programmes was that they were carried out through national institutions and WHO's role was chiefly one of promotion, stimulation and coordination.

Those special programmes had been created on the basis of the existence of potential voluntary extrabudgetary financing, which might come from governments, external or paragovernmental cooperation agencies of Member States, private foundations or United Nations bodies such as UNDP or the United Nations Fund for Population Activities (UNFPA). They had often been created in highly sensitive ethical, scientific or political areas in which WHO's role, in addition to providing technical support, was that of a guarantor of neutrality in the use of the voluntary resources. The point raised by various delegates had often been discussed at the Health Assembly, at the Executive Board and at the annual meetings of agencies and governments interested and participating in those special programmes. Many different points of view had been expressed about them. At the Committee's previous meeting, it had been suggested that the amount allocated to them from the regular budget should be increased. Yet the Executive Board, at its seventy-first session, in January 1983, when discussing the proposed programme budget for 1984-1985, had considered that, in view of the large amount of voluntary extrabudgetary resources available for the programme, the allocation from the regular budget for human reproduction research should be reduced.

Another point to be borne in mind was that, with zero growth in the programme budget as a whole and a 4.2% increase for country-level activities in real terms, any increase for a given programme would have to be achieved by cutting some other programme.

With regard to the programme on human reproduction research, it had sometimes been maintained that an increase in the regular budget would give outside bodies an indication of the priority accorded to the subject by the Organization and would thus encourage voluntary contributors to give more and other bodies to begin to contribute. It was also not unusual for United Nations bodies to accord high priority to a programme and at the same time to call for voluntary extrabudgetary contributions. That had happened in the case of several of WHO's programmes. Obviously, as some delegates had suggested, the Executive Board might at some time consider ways of solving the problem since it was one of budgeting policy.

Dr PETROS-BARVAZIAN (Director, Division of Family Health), replying to questions raised about programme 9.1 (Maternal and child health, including family planning), recalled that the delegate of Nigeria had enquired about the Organization's activities and programmes in the areas of population, health and development and, in particular, about the International Conference on Population which had taken place in Mexico City in August 1984. The Organization had no separate programme on population, health and development, since
population and development were closely linked with many of UNICEF's programmes. There was, however, a focal point in the Division of Family Health for coordination of all activities in that area, closely linked with the programmes on human reproduction research, health situation and trend assessment and many other UNICEF programmes, under both health science and technology and health system infrastructure.

WHO had participated in the International Conference on Population, which had reaffirmed many of the elements of WHO's own policies concerning maternal and child health, including family planning. WHO had actively participated in all preparatory stages of the Conference and had prepared scientific and technical papers which had formed the basis of the health recommendations resulting from it. WHO's delegation had been headed by the Director-General and had included representatives from all regions. Some of the recommendations of the Conference were similar to, or the same as, some of the activities and programmes included in WHO's programme budget and in the global and regional strategies for health for all. They concerned the reduction of maternal and child mortality and morbidity and the relationship between too early, too close, too many and too late pregnancies and the health risks to mothers and children; they included adolescents' health, the status of women, and the importance of biomedical and health service research. In relation to the Conference, a large amount of documentation had also been prepared for public dissemination and ways had been worked out of cooperating with professional and nongovernmental organizations to follow up the recommendations. The strategies for health for all provided the framework for follow-up action on the health-related recommendations of the Conference. More important than those global-level activities was WHO support action at country level in close collaboration with UNICEF, in supporting the application of maternal and child health, including family planning technologies, in more than 90 countries in all regions. In many countries, WHO was also collaborating closely with UNICEF in support of national efforts in that area.

With regard to other questions raised in connection with the programme, WHO's cooperation with UNICEF was particularly close and addressed the issue of maternal and child nutrition in a broad sense in the context of primary health care and the strategies for health for all. In that regard, the major areas in which WHO collaborated with UNICEF included nutrition during pregnancy and lactation; the promotion and protection of breast-feeding; appropriate locally available weaning foods; education of the public and education and training of health workers at all levels; and the social status and education of women as it affected child care and child nutrition. That included the issue of opportunities for the social support of women during breast-feeding.

Together with ILO, WHO had recently prepared a global survey of existing national maternity legislation, published in the ILO series entitled Women at Work.¹

She welcomed the comments on the need for WHO to support Member States in their efforts to protect and promote breast-feeding and referred to paragraph 5 of the programme statement for programme 9.1 in relation to the desire expressed by Member States that declining trends in breast-feeding which had been noted a decade ago in some countries should be prevented in rural areas of developing countries.

With regard to the requests that WHO should convene a meeting to clarify certain scientific and technical questions connected with breast-milk substitutes, she informed the Committee that the Director-General had already decided, in collaboration with UNICEF, to convene such a meeting later in the year to develop guidelines which Member States might wish to use in defining for themselves, based on their individual national circumstances, the meaning of the phrase "infants who have to be fed on breast-milk substitutes" and to deal with any other related technical matters.

With regard to the question of the delegate of Qatar concerning steps taken to give effect to Health Assembly resolution WHA37.30, she informed the Committee that Member States were currently preparing a report, through their respective regional committees, on the action they were taking in the overall field of infant and child nutrition. That information, together with its examination from a technical and scientific standpoint in the light of the issues in the resolution, would be included in the Director-General's next biennial report to be submitted to the Thirty-ninth World Health Assembly, as requested in operative paragraph 3 of the resolution.

In reply to the question by the delegate of Egypt about the difference in levels of the extrabudgetary resources for the programme, she drew attention, in addition to the policy issues just expounded by the Assistant Director-General, to paragraph 31 of the programme statement which explained that, because of the differences in the budget cycles of WHO and UNFPA, the estimates were only tentative and that some funds which were not shown in the proposed programme budget might be forthcoming at a later stage to make up the shortage.

¹ Women at Work, No. 2, 1984.
Finally, she agreed with the comments by the delegate of Kenya. The subject of women, health and development would be discussed in Committee B under agenda item 33.2 in connection with the Director-General's report (document A38/12).

Dr BELSEY (Maternal and Child Health) said that there was full agreement on the need for an integrated and balanced programme of maternal and child health and family planning techniques within primary health care, as had been made clear by delegates including those of Lesotho, Sierra Leone, Nepal, Bulgaria and Indonesia.

Experience had shown that the leading edge of primary health care might vary from country to country in accordance with the historical development of national health systems, whether such systems evolved from the Expanded Programme on Immunization, which had its roots in the smallpox eradication programme, or from family planning or the classical maternal and child health care. What had not varied, or should not vary, was the commitment to grasp every opportunity to build and strengthen the infrastructure needed to establish integrated primary health care systems of which maternal and child health and family planning were essential elements.

The delegate of Indonesia had rightly pointed out that the means of achieving that integration were management, including supervision, and management training in integrated primary health care, including all the elements of maternal and child health and family planning. He (Dr Belsey) and his colleagues were pleased to note that the development of guidelines, training modules and managerial tools for integrated maternal and child health and family planning (MCH/FP) activities and technologies within primary health care was high on the list of programme priorities. The maternal and child health programme had been cooperating with many other programmes, such as nutrition, the Expanded Programme on Immunization, Diarrhoeal Diseases Control Programme and primary health care, in the developing and testing of managerial tools such as the joint programme reviews.

He agreed with the delegate of Bulgaria that the human genetics programme should be included in the integrated approach. Although it was not administratively part of MCH/FP, the human genetics programme dealt to a large extent with matters of relevance to child health and was closely linked and coordinated from the point of view of programming with the MCH/FP programmes.

The development of training modules for middle-level management and supervision for MCH/FP was being actively pursued and would be speeded up. WHO headquarters and regional offices welcomed the opportunity of cooperating with Member States in support of such training and in technically supporting national efforts at integrating the various MCH/FP technologies within health systems based on primary health care.

Replying to the delegate of Israel on the application of the risk approach in MCH/FP, he said that a Public Health Paper had been published on the risk approach in health care, a training workbook on how to plan and carry out research on the risk approach had been produced, and accounts of country experiences in the application of the risk approach were in preparation. In addition, there had been several dozen training workshops at regional and country levels for MCH/FP programme managers, who had incorporated the concepts and methodologies of the risk approach in their ongoing programmes. The approach was being extended, with the approval of the UNICEF/WHO Joint Committee on Health Policy, to application at community level with the appropriate adaptations which would include the training and linkage of primary health workers and traditional birth attendants. That had been done with success, as had been pointed out by the delegate of Mali, who had rightly emphasized the need to strengthen referral centres. Such centres were indispensable in achieving any significant reduction in maternal and perinatal mortality.

The delegates of Nigeria, Norway, Sierra Leone, Trinidad and Tobago, Turkey, Uganda and others had noted that pregnancy during adolescence, which was associated with very high risks of mortality to both mother and infant and was accompanied by severe health, psychological and social consequences, represented a major obstacle to the overall improvement of maternal and child health. As most adolescents successfully coped with their often difficult transition to adulthood and responsible parenthood, programme activities in adolescent health were trying to build on those successful experiences and on the natural creativity and idealism of the young, and were also involving young people in promoting the understanding

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1 See p. 265.


and care of their health needs and those of others. Within the context of the local social and cultural patterns creative forms of health education, such as youth theatre groups and self-help, were among the approaches adopted. The report of the Study Group on Young People and Health for All by the Year 2000, currently in the press, would reflect that approach. Action-oriented research and programme development training workshops were being organized in most regions in response to the increasing awareness of Member States.

The delegate of Swaziland had pointed out that some of the health-care practices of hospitals, clinics and other health facilities could actually undermine or interfere with breast-feeding. To draw attention to that problem, WHO had cooperated with UNICEF in producing a film and guidelines for discussion groups and workshops to be used in reorienting and training health-care providers and administrators on health-care practices to encourage breast-feeding. An annotated bibliography on such practices was due to be printed in the current year as well as other promotional and technical materials on health care practices, the relationship of breast-feeding to child spacing and contraception, and other related subjects.

The delegate of Trinidad and Tobago had noted the difficulties in reducing that half of infant mortality associated with the neonatal period or, more specifically, perinatal mortality. The delegate of Zimbabwe had described the role of maternal nutrition and care as a factor in perinatal and infant mortality. To assist Member States to develop locally relevant and appropriate techniques for dealing with such problems as perinatal mortality and low birth weight, the maternal and child health programme was making use of a network of collaborating centres to develop and evaluate simple, cost-effective and socially relevant techniques, such as a labour monitoring system for primary health workers and traditional birth attendants, surrogate simpler measurements for birth weight, and simple kits for delivery care.

A register of randomized controlled clinical trials of pregnancy and delivery technologies had been supported by that programme and would be printed in the current year. A consultation, jointly sponsored by the programmes on nutrition and maternal and child health, including family planning, would be held in the summer to consider the methodological and substantive issues of low birth weight and maternal nutrition.

Dr. BARZELATTO (Director, Special Programme of Research, Development and Research Training in Human Reproduction) thanked delegates for their support of the Programme and for the comments made that would help in guiding it. Various delegates had advocated that greater emphasis should be placed on a number of aspects of the Programme, including applied research, health services research, the strengthening of research capabilities, infertility, safety and efficacy. He said that the Programme was mission-oriented and basic research was only exceptionally supported for justified strategic reasons. Applied research constituted the very essence of most of the activities.

The final objective of the Programme was to improve, through research, the access of couples to safe and adequate methods of fertility regulation, both in respect of contraceptives and infertility. Health services research and health systems research were very important aspects of the Programme in order to meet that final objective. Those activities were being reorganized in close cooperation with the programme on maternal and child health, including family planning, and with regional offices, in order to expand them and to improve their effectiveness.

The delegate of China had referred to resources for research. Those covered the strengthening of research capabilities and the maintenance of an active network of centres working with the Programme and, more importantly, with one another. The human reproduction programme was directed mainly towards developing countries, and their needs would continue to be a major component of the Special Programme. The Special Programme placed great value upon research into infertility, to which attention had been drawn by the delegates of Gabon, Uruguay and the USSR. There was also close cooperation on that important component of the Programme with the programme on maternal and child health, including family planning. Adequate funding would make it possible to increase and accelerate programme activities in that and other components. However, there had been a shortfall in the amount of voluntary contributions to the Programme, so that not all plans approved by the Scientific and Technical Advisory Group could be implemented. It was hoped that that situation would improve in the near future.

He agreed with the delegate of Egypt on the importance of the long-term assessment of the risks, benefits and effectiveness of existing contraceptives. A special task force had been set up on that matter, which had so far been dealt with by several different task

It was the intention to expand those activities for which WHO was particularly well suited. Long-acting systemic agents were among the priorities drawn up by the new task force.

Dr EL BATAWI (Office of Occupational Health) said that WHO had been studying the relationship and developing the integration of the programme on workers' health with primary health care since the adoption in 1980 of resolution WHA33.31, which had requested the Director-General to formulate guiding principles on the organization of occupational health care at national level, in collaboration with ILO and other agencies concerned. Workers' health had not been included in the eight essential components of primary health care in the Declaration of Alma-Ata, but that Declaration implied health care delivery to people where they worked, as well as where they lived, and endorsed the goal of health for all by the year 2000 for socially and economically productive populations, in short for workers. However, that had to be explained to health planners in various parts of the world. To that end, a paper for worldwide distribution setting forth the general theoretical considerations on the interrelationship between primary health care and health care for the working populations had been produced. Then models and feasibility studies on the extension of health services following the primary health care approach had been developed in no less than ten countries. The third line of approach was to obtain a consensus among health planners in the various countries as to their responsibilities for the health of workers as part of the general population. Primary health care experts had been brought together with their occupational health counterparts at meetings held in the South-East Asia Region and the Region of the Americas, and similar meetings were planned for the current year in the European Region. It was hoped to organize an interregional conference at the end of 1985.

Close cooperation with ILO was necessary, since that Organization had a legislative approach to occupational safety. Primary health care workers needed that legislative support. Replying to the delegate of Iraq, he said that active steps were being taken to give effect to his suggestion for the designation of the Institute of Occupational Health, Baghdad, as a WHO collaborating centre.

Repeating the reply of the United Republic of Tanzania, he said that activities regarding workers' health in the African Region fluctuated in accordance with the requests made by countries. However, a revision of the medium-term programme would soon take place and he thought that a resolution, as suggested by the delegate, should not be adopted until some firm conclusions had been reached as to the interrelationship between workers' health care and primary health care systems and their integration.

Repeating the reply of Poland, who had referred to the increase in budget support, he pointed out that the increase in the budget for workers' health as set out in the proposed programme budget was only at the regional and country levels. The allocations currently were made mainly in response to country requests and that reflected increasing interest in the development of national workers' health programmes.

He assured the delegates of the German Democratic Republic and the USSR that their offer of services and experience to developing countries would be taken up. Courses would be organized in the fields of agriculture, health care for specific vulnerable groups of the working population and other subjects. He also reassured the delegate of the USSR: no change was contemplated in the definition of occupational diseases. The aim was to widen the scope of care of factory physicians and of occupational health care programmes, and to abandon the one-disease one-cause approach. All illnesses in workers that were work-related should be considered as a whole. That matter was dealt with in an expert committee report to be submitted to the next session of the Executive Board.¹

The question of undergraduate training, raised by the delegate of Malta, was one of the subjects to be considered by a recent expert committee within the context of the budget currently under consideration.

The question of the work-load of women in agriculture, raised by the delegate of Uganda, was dealt with in a report of a recent Expert Committee on Occupational Health for Working Women in different parts of the world.

Repeating to the delegate of Bulgaria, he said that extrabudgetary funds would be used for research on the risk factors inherent in the new information technologies, to which she had referred. There would be a meeting on visual display terminals and health before the end of the current year.

Finally, he assured the delegate of Tunisia that the Institute of Occupational Health in his country would be one of the WHO collaborating centres.

Dr MACFADYEN (Programme on Health of the Elderly) said that he would summarize the comments of the delegates under three headings; family and social solidarity, programme articulation, and resources.

Family and social solidarity was referred to in paragraph 9 of the programme statement and had been dealt with by the delegates of Kuwait, Jordan, Iceland and Canada. He considered it to be a key issue for both developed and developing countries, especially as between different generations.

As for programme articulation, the delegates of Japan and Bulgaria had called for articulation with the programme on nutrition. The delegates of Malta and Cook Islands had asked for articulation with the programmes on education and training. The delegates of the Federal Republic of Germany and of Israel had asked for information on what was in fact being done with regard to the oral health of the elderly. He wished to assure those delegates that, in the planned programme for 1988-1989 and in the current programme, there were joint activities in those areas with the relevant headquarters programmes. The most important aspect of programme articulation had been highlighted by the delegates of Norway, Czechoslovakia, Iceland and Sri Lanka, namely that with primary health care. Paragraph 7 of the programme statement made it clear that it was the policy of WHO to provide health services for the elderly as part of the general health service and not as separate services. The programme articulation taking place at country level - as, for example, that of an African country's training programme in family health that he had seen - consisted of the four elements of mother care, child care, family planning and care for the elderly.

With regard to resources, the programme had been offered help by academic and scientific institutions in Hungary, the USSR and Bulgaria, and those offers from delegates were most welcome.

An innovative proposal had been made by the delegate of Norway that the elderly should themselves be regarded as resources and should be involved in programme activities. He welcomed the suggestion that WHO might even have a programme for the elderly run by the elderly. The new Regional Director for Europe intended that elderly people should participate in planning the programme for 1988-1989.

Referring to the comment of the delegate of Israel on the amount of work done in relation to the scant resources, he said that the programme certainly needed the resources included in the proposed 1986-1987 programme budget. The requirements for the future were also a matter of record; they included the addition of a nursing component to the programme. The delegate of Czechoslovakia had rightly stressed the importance of nursing in the care of the elderly; good nursing practice was "enabling", i.e., it helped elderly people and did not merely take care of them.

He wished to reassure the delegate of Israel that the programme on the health of the elderly was not a personal plan of action but the collective aspirations of colleagues in the regions and himself for the period 1986-1987. He concluded by thanking delegates for their generous and kind comments on those aspirations.

Protection and promotion of mental health; Promotion of environmental health; Diagnostic, therapeutic and rehabilitative technology (programmes 10-12)

The CHAIRMAN called on Dr Borgoño, representative of the Executive Board, to introduce those programmes.

Dr BORGOÑO (representative of the Executive Board), introducing the group of programmes, stressed the need for the integration of the programme for the protection and promotion of mental health (programme 10) into primary health care, involving not only technical knowledge of psychological behaviour but also the need to train personnel in basic principles to enable programmes to be integrated in the most efficient, timely and complete way. Experiences in various countries justified the belief that such integration was both possible and highly desirable. Another aspect of the programme was the identification of high-risk groups, which was important in order to enable resources to be used in the most rational, efficient and economical way. A number of such groups had been identified: the elderly, immigrants, children of separated or divorced couples or of mentally ill parents. There were obviously many others.

1 See document EB75/1985/REC/2, page 226.
The Executive Board had considered the problem of the prevention and control of alcohol and drug abuse to be of great importance. The subject had been much discussed and he would merely say, with reference to resolution WHA36.12, and to resolution WHA37.23, that, according to the information which the Board had received, very satisfactory progress had been made with their implementation; that constituted an important step forward. The Director-General had been requested to give particular emphasis to the programme on alcoholism and to make increased funds available to it. With regard to the control of drugs and narcotics, various international meetings had been held and considerable progress made as a result. Much remained to be done, but he thought that the Organization was on the right road.

One final point he wished to make concerning the mental health programme was the need to evaluate the psychosocial factors of development, and the tools and methodology for so doing, particularly with a view to determining the nature and extent of the problems, and, in turn, emphasizing, in close coordination with the maternal and child health programme, the promotion of the normal psychological development of the child and the early psychological stimulation required by babies and young children.

Concerning programme 11 (Promotion of environmental health), he stressed that important progress had been made in connection with the International Drinking Water Supply and Sanitation Decade. Nevertheless, much remained to be done especially with regard to the provision of potable water; to that end, bilateral and international cooperation needed to be improved. It was also necessary to strengthen the infrastructure of countries in different sectors to permit the best possible use and management of available resources in terms of water supply and sewerage systems.

In relation to the development and promotion of urban and rural housing, the cooperation that had been established with the United Nations Centre for Human Settlements (HABITAT) and UNEP was of great importance. With regard to the control of environmental health hazards, anyone who read the newspapers would appreciate the importance of the relevant programme and of the International Programme on Chemical Safety. The coordination of those two programmes was essential, since it was very difficult to separate clearly the functions of each of them: risk evaluation and risk control management were closely connected, even if each of those programmes placed particular emphasis on one or other of the two areas.

Those programmes were particularly important from the point of view of the ever increasing problems faced by the developing countries; although the developed countries also had problems, priority should be given to the developing countries so that they could benefit from the experience that the former were acquiring. Monitoring and evaluation, as well as staff training, were all matters of prime importance.

Finally, progress had been made in food safety and surveillance, thanks to strengthened coordination, especially with FAO, that made it possible to provide countries with information to help them to develop their programmes efficiently and to have an impact on other problems caused by food contamination, such as diarrhoea, particularly among children.

Turning to programme 12, and referring to clinical, laboratory and radiological technology for health systems based on primary health care (programme 12.1), he mentioned the need gradually to establish a network of peripheral laboratories as a support for primary health care services, instead of concentrating on large laboratories in more advanced hospitals, whether secondary or tertiary. That need should be reflected not just in agreements in principle, but in effective action, since when countries were visited it was found that words and deeds were not always one. The Board had highlighted the need for such a network, since it would facilitate not only better clinical diagnosis but also epidemiological surveillance. There was also a need for a rational and well-informed approach to the equipment requirements of laboratories; the simplification of such equipment, both in clinical and public health laboratories, as well as in radiology, would constitute highly significant progress.

Programme 12.3 (Drug and vaccine quality, safety and efficacy) had enjoyed unusual prestige and had been very effectively developed. He paid personal tribute to the work of the late Dr Perkins in that field. It had been possible to promote appropriate legislation and standards for the quality of pharmaceutical products and vaccines, and to make progress in other directions, all of which represented a remarkable achievement, stimulated by the resolutions of successive Health Assemblies.

There had also been important progress in implementing programme 12.2 (Essential drugs and vaccines). Guidelines and manuals had been prepared to facilitate the establishment of national policies, standards and essential drug programmes. The contribution made by some organizations and bodies of the United Nations system, such as UNICEF, was highly relevant in that regard. In January 1985 the Executive Board had asked the Director-General to make available increased extrabudgetary funds for the programme and to make all possible efforts to increase those funds in order to make progress in all the rather complex aspects of the
programme. Progress had also been made in the indispensable training of personnel needed to cover all the stages of the programming process, ranging from the administrative aspects of tendering, handling and distribution to technical aspects involving quality, use, efficacy of and need for drugs and vaccines.

Various nongovernmental organizations were increasingly adopting the principles of the programme, thus helping to strengthen and extend it, so that greater attention could be given to meeting the needs of countries in terms of assistance from such international bodies. Discussions were also continuing with the pharmaceutical industry based on the principles discussed many times in Health Assemblies.

The evaluation and monitoring part of the programme had been formulated for the period 1984–1989, and information was being supplied to governments to enable them to fulfil their commitments and establish national action plans and draw up lists of essential drugs in accordance with the Organization's recommendations, wherever that had still not been done, so that a programmed supply of such drugs would be available.

Finally, he informed the Committee that in response to the request made to the Director-General at the previous Health Assembly (resolution WHA37.33) arrangements were in hand for all the parties concerned to meet in a conference of experts on the rational use of drugs to be held in Nairobi from 25 to 29 November of the current year; Dr Kaprio had been appointed Executive Secretary.

Traditional medicine (programme 12.4) was making an important contribution and was becoming of ever increasing interest in the various countries of the world wishing to take advantage of the traditions existing in many Member States.

Programme 12.5 (Rehabilitation) was obviously of growing importance. Its focus should be above all preventive, in that the need for rehabilitation should be avoided wherever the tools and knowledge permitted. However, when handicaps did develop, the programme had to become fully active, and should be integrated into primary health care activities, going beyond the locomotor system, which was the centre of interest in most countries, to include the organs, the senses and chronic illnesses such as respiratory and cardiovascular diseases. The programme would be of increasing importance in all countries and was having vast repercussions, especially in the developing countries. The training of personnel and the establishment of national programmes and policies were essential tools for attaining the goals that had been set in the programme.

Lastly, he appealed to the Committee to focus the discussion on the budgetary aspects; feedback was wanted on budgetary policy, since that was what was being discussed, and not programmes as such.

Protection and promotion of mental health (programme 10)

Dr WESTERHOLM (Sweden) said that the consumption and production of alcohol constituted an important element in any health development analysis; her delegation therefore noted with satisfaction the recent WHO publication entitled Public health implications of alcohol production and trade.¹ The data and analyses contained in the study would certainly provide important background material for Member States when developing comprehensive alcohol-control programmes.

However, she found the situation analysis in the proposed programme budget somewhat alarming. Although Sweden and other European and North American countries were reporting a levelling off and even a modest decline in alcohol consumption, the global trend continued upwards with particularly sharp increases in commercially produced alcoholic beverages in some developing countries. That global trend was likely to have enormous public health implications, and it was therefore important for WHO to support the development of programmes for prevention, education, treatment and management, and to put them into practice in collaboration with Member States. It was especially important to develop programmes that could be integrated within primary health care services.

Recalling operative paragraph 4(2) of resolution WHA36.12 requesting the Director-General to ensure that the necessary organizational, staffing and budgetary implications for the Organization were taken into account in preparing the programme budget for 1986–1987, she believed that, in order to be able to implement the programmes in the budget, the position of WHO as programme manager for the global alcohol programme, at present financed with extrabudgetary funds for one year, should be made permanent during the coming biennium.

With regard to drug abuse, she pointed out that the situation had never been graver. Both production and abuse of drugs had risen steeply during the past decade. The rapidity with which cocaine abuse was currently spreading throughout the world was particularly disturbing. WHO had estimated that there were 48 million drug abusers in the world. The tragedy of that rapid increase was that many developing countries had increasing problems. Owing to the frequent lack of drug control, they were also facing a growing abuse of psychotropic drugs. Her delegation noted with gratification that WHO had developed its important work in investigating which drugs should be classified as narcotics and made subject to international control. Since no country could by itself put a stop to illegal drug trading and drug abuse, powerful multilateral cooperation was needed, including action by WHO.

It was encouraging to see that some increase had been made in WHO's budget for combating alcoholism and drug abuse, but if WHO was to be able to take the action needed it must accord higher priority to the programme in the regular budget.

Dr TIDJANI (Togo) said that his delegation fully associated itself with the views of the Executive Board on the proposed programme budget, especially in regard to programme 10. In most of the developing countries the drawing up and implementation of a mental health programme generally encountered two main obstacles: first, the lack of qualified personnel; and second, the difficulty of adapting the programme to the country's sociocultural conditions, and especially to traditional medicine. That was one of the reasons why the developing countries invited WHO and the specialized agencies to increase their efforts and to intensify their collaboration with ministries so as to be able to identify more precisely the problems specific to each country and find appropriate solutions as rapidly as possible.

The meeting rose at 11h15.
EIGHTH MEETING

Tuesday, 14 May 1985, at 14h40

Chairman: Dr D. G. MAKUTO (Zimbabwe)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1986-1987: Item 22 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II) (continued)

PROGRAMME POLICY MATTERS: Item 22.2 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II, Chapter II) (continued)

Health science and technology - health promotion and care ( Appropriation Section 3; Documents PB/86-87, pages 106-199; EB75/1985/REC/1, Part II, Chapter II, paragraphs 37-56; A38/INF.DOC./3; A38/INF.DOC./4; A38/INF.DOC./7; and A38/INF.DOC./11) (continued)

Protection and promotion of mental health (programme 10) (continued)

Dr REZAI (Islamic Republic of Iran) said that his delegation strongly supported programme 10, particularly with regard to the prevention and control of alcohol and drug abuse (programme 10.2). Alcohol was the only psychotropic drug that was consumed in most communities with practically no ethical and sociological restrictions; moreover, the cultural traditions of most communities encouraged the consumption of alcohol. To say that alcohol consumption created only individual health problems was no excuse, and society could not and should not remain indifferent to those problems. Increases in the commercial production of alcoholic beverages were clearly accompanied by increases in the rate of consumption and the number of consumers. Alcohol was a threat to the consumers' personal, family, sociological, economic and professional relations. A mind affected by alcohol was careless and assumed false and unfounded courage. The rate of accidents, crimes and other catastrophes perpetrated under the influence of alcohol could not be compared at all with the rate due to other causes. If laws were designed to safeguard people and protect them from danger, they must emphatically prohibit the consumption of substances which endangered society; commercial propaganda for alcohol could only lead society towards destruction. Increased alcohol consumption by young men and women directly exposed the administrators and mothers of the future to danger. In face of the proven fact that alcohol damaged the health of individuals as well as that of society, how could governments and private manufacturers support the production of a poison that led the individual and society to annihilation? The problem of alcohol consumption and its control was of course very complex, but there could be no doubt that the campaign against it must be based on the principle of decreasing production and thus bringing an end to both supply and demand. By totally prohibiting the consumption of alcoholic beverages Islam had solved all the relevant problems, and that religious sanction had created an alcohol-free culture. In the Islamic Republic of Iran, with its strict implementation of Islamic law, the production, consumption and exchange of alcoholic beverages were prohibited. The demand for alcohol was a complex matter, closely related to culture, creeds, and historical and socioeconomic conditions; in Islamic communities the sanctions regarding alcohol and appropriate propaganda could be very effective.

Since alcohol was a psychotropic drug because of its effects on behaviour and intellect, and since it created physio-psychological dependence, it was clearly an addictive substance. Its inclusion among controlled substances should therefore be considered, and WHO should become more active in that field.

Dr DE KOCK VAN LEEUWEN (Netherlands), referring to programme 10.2, said that his delegation welcomed the main lines of WHO's action for the prevention and control of alcohol abuse - namely, advocacy of public health measures for the prevention and control of alcohol-related problems, the development of techniques for the identification, prevention and management of alcohol problems in individuals, families and communities, and collaboration with countries in the development of national alcohol policies. Per capita
alcohol consumption in the Netherlands had more than tripled since 1960, and at the present time the average drinker consumed about 1000 standard glasses of beer, wine or distilled beverages per year, each glass containing about 10 cc of pure alcohol. The 10% who were the heaviest drinkers accounted for almost half of the total alcohol consumption, and although the percentage of drinkers in the population had not increased greatly over the past decades those who did drink did so more frequently and in greater quantities per occasion. About 50% of all alcohol was consumed in the form of beer, 30% as distilled beverages, and 20% as wine. The consumption level of alcoholic beverages had stabilized over the past few years, as seemed to be the case in other western countries. The rise in the level of alcohol consumption was associated with an increase in individual and social problems, and several large-scale surveys conducted recently had indicated that some 7% of all drinkers admitted experiencing alcohol-related problems. The high prevalence of alcohol-related traffic accidents had led to a campaign through the mass media with a view to reducing drinking when driving, and the promotion of moderation in drinking was stressed in health education programmes. In the health and social care system efforts were made to heighten the awareness of personnel in the recognition of individual problems associated with the excessive use or abuse of alcohol, and special attention would be paid to the relationship between alcohol use and criminality in an action plan which was now under consideration by the Netherlands Government.

Economic factors undoubtedly affected the incidence and prevalence of alcohol abuse, and influence on such factors might contribute directly or indirectly to the control of alcohol-related diseases and social problems. It was clear, however, that measures specifically directed at problem users or problem situations - such as violence associated with alcohol use in football stadiums - generated more political and popular support than measures directed towards reducing the supply of alcohol itself. A broadly-based alcohol policy was being developed in the Netherlands, using, inter alia, the documented experience of other European countries. In that connection, the Netherlands was participating in a European regional collaborative project involving eight Member States in the promotion of studies of alcohol-related problems and the responses to them at the community level. The Netherlands would cooperate with WHO, to the extent permitted by its resources, in the development of alcohol programmes at the global and regional levels.

The publication on strategies and guidelines for prevention of drug abuse referred to in paragraph 14 of the programme statement was badly needed; at the same time, where the health education aspect was concerned, an integrated preventive approach to alcohol, tobacco and drug abuse was desirable, and it was to be hoped that the guidelines provided in the forthcoming publication would also be applicable in principle to the use of mind-altering substances other than drugs.

With regard to programme activities concerning narcotic and psychotropic substances (paragraphs 17-19), the Director-General was to be congratulated on the rapid implementation of the new WHO procedure for the review of psychoactive substances for international control. That procedure would certainly represent a step forward in establishing WHO's authority in the assessment of public health and social problems associated with the use of psychoactive substances. Nevertheless, appropriate use of official information on those problems at the global level depended on the application of data-gathering systems by the Member States themselves. Much work remained to be done in close relationship with national control systems to ensure the therapeutic efficacy and safety of medicinal drugs; it should be borne in mind that at the present time the assessment of the safety of a new drug during the registration procedure did not normally include an assessment of dependence liability of the drug prior to its marketing, and also that drug dependence was not easily ascertained through systems of monitoring adverse drug reactions after the drug had been marketed. That was a gap which needed to be narrowed both by Member States and by WHO.

Dr ABDULLATIF (Democratic Yemen) expressed his delegation's support for programme 10.2. There could be no doubt that drug abuse was a major problem in some countries. A relevant form of action by WHO in that regard would be to strengthen the connection between that programme and the one on essential drugs - for instance, by promoting legislation concerning the marketing and prescription of obsolete drugs, which was prevalent in some developing countries. Such measures, if properly implemented, could probably prevent a certain amount of drug abuse. That link should be emphasized in the programme activities, since it would strengthen the concept of integration which was so essential for all WHO programmes.

Dr OWER (United Kingdom of Great Britain and Northern Ireland) said that he would concentrate his remarks more specifically on drug abuse, because the current explosion of drug misuse in many countries highlighted the crucial importance of that particular issue. The chief delegate of the United Kingdom had addressed the Health Assembly on that subject at the eighth plenary meeting and had made a number of important points which he wished to
repeat in the Committee. In the first place, there was the need to prevent individuals from experimenting with illegal drugs, and health education, especially for young people and their parents, was vital in that connection. Secondly, there was the need to detect drug abuse and to establish the magnitude of the problem; the United Kingdom had an efficient system of monitoring drugs prescribed under the National Health Service which identified not only doctors who were heavy prescribers of addictive drugs, but also, in certain circumstances, individuals who were consumers of those drugs; that of course did not help to combat the use of illicit drugs but had some impact on a small though important part of the problem. Thirdly, there was the need for effective treatment and rehabilitation of those who had become addicted, involving community services wherever possible, so that local people could play their part. Fourthly, there was the need for evaluation of treatment methods and of other components of the programme. Finally, there was the problem of addiction to legally prescribed drugs. Doctors in the United Kingdom had already had considerable success in voluntarily controlling the prescription of amphetamines and barbiturates, and many of them had eliminated the use of those drugs from their practices altogether. The problem of non-barbiturate sedatives and tranquillizers, particularly the benzodiazepines, was now being given attention. Nevertheless, the problem of illicit drug trafficking and consumption remained and unfortunately seemed to be increasing in some areas. That was why the United Kingdom attached such importance to the subject and urged all delegations to support and develop the proposed programme.

Dr LEFFPO (Finland) said that his delegation had advocated a more active and more clearly enunciated WHO policy and programme on alcohol-related problems on several previous occasions and therefore noted with special satisfaction the great progress made in response to resolution WHA36.12 adopted two years previously. That progress was reflected both in the programme statement on programme 10.2 and in the report on alcohol consumption and alcohol-related problems contained in document A38/INF.DOc./4. Finland welcomed the comprehensive approach adopted in the programme and agreed entirely with the major lines of action — advocacy of the public health interest, national alcohol policies, development of techniques in the context of primary health care, and international coordination.

Although the programme was now very well conceived, his delegation was concerned by the question of the funds required to implement it. It was difficult to find out what sums and manpower were involved from the programme budget document, even from the detailed tables on pages 402 and 403, but according to the information in paragraphs 26 and 27 of document A38/INF.DOc./4 the programme relied almost entirely on extrabudgetary funds, temporary staff and short-term secondments. His delegation hoped that future programme budgets would show an appreciable increase in the budgetary allocation to the programme, which deserved more funds — for the problem was serious throughout the world, WHO was the only United Nations body that was really active in the field, international efforts to control alcohol abuse were minute compared with those devoted to other forms of drug abuse, and there was now a sound WHO programme which could only be implemented efficiently with adequate funds.

Dr MURRAY (Grenada) expressed her delegation's firm support of WHO's proposed mental health programme and budget allocations. A review of Grenada's mental health services conducted in the past year had shown that a significant number of patients in the mental hospital were alcoholics who were continually being readmitted. A new community-based residential unit for the treatment of alcoholism and other drug problems had now been opened, but the authorities in her country strongly believed that the real test of any such programme lay in the results obtained after discharge and long-term follow-up in the community. Grenada was therefore pleased to note the attention that WHO was paying to those problems, which were continuing to increase in most areas of the Caribbean. It looked forward to cooperating in WHO's new initiatives.

Professor HUTAS (Hungary) said his delegation agreed with WHO's focus on the wider category of alcohol-related problems rather than just on alcoholism. Intensive research in Hungary had led to the conclusion that it was a problem to be tackled by society as a whole and not just the health sector. Steady, systematic and coordinated intersectoral activities would be required to change unfavourable trends, a task which would certainly take some time. A multisectoral committee had been established in Hungary to deal with alcohol-related problems. Headed by the Deputy Prime Minister, it was responsible directly to the Council of Ministers, and had the necessary authority to organize coordinated intersectoral activities.

He supported the active detection and care of at-risk groups at the community level and through primary health care, and the treatment and social rehabilitation of those in need. Hungary had had some success in that respect with Alcoholics Anonymous clubs.
In Hungary alcohol-related problems were dealt with under mental health programmes, in conformity with WHO's concept. A network of dispensaries for alcoholics had been established and was being developed further. In-patient care and facilities for social readaptation were also being provided. Special attention was given to the care of young people and adolescents at risk, with additional activities in respect of drug abuse and toxicomania. Health education was an important means for achieving results in that respect.

Alcohol-related problems could only be solved through coordinated social measures at the national level, although they would require support through international cooperation, research and exchange of experience. His country would continue its efforts to promote activities in this field.

Dr PAL (Pakistan) said that programme 10 was a key programme in the strategy for health for all. Continuous efforts were required to protect and promote mental health from the moment of conception. Mothers therefore required affection as well as good nutrition and in turn had to give their babies the right start through breast-feeding - perhaps one of the earliest factors in promoting mental health. Emotional wellbeing was as important as physical environment in creating the home. Greater attention should be paid to the causes of emotional and psychological disturbance, leading to pathological disturbance. Protection, particularly for children against avoidable psychological traumas and accidents resulting from alcohol, narcotics and psychotropic substances was essential.

Policies and decisions should be pursued more aggressively to ensure that desirable objectives were attained, with the promise of health and happiness, and that the misery and fear associated with alcohol and drug abuse and mental illness health could be avoided.

In the metaphorical sense "sanity" was a prerequisite for the attainment of health for all by the year 2000. Mental health should be given great priority, with commensurate budgetary allocations.

Dr WALSH (Ireland) said his delegation strongly supported programme 10. Ireland’s planned policies on alcohol-related problems were very similar to those of WHO, as indicated in a recently published report on the planning of future psychiatric services. They emphasized prevention rather than treatment, with a positive approach to life-style rather than a "do not" type of health education. Activities would be largely community-based, recognizing the importance of general practitioners and other primary health care personnel, because of their credibility with the people they were trying to influence. Attempts were being made to draw up a national policy on alcohol consumption – a difficult task, since it required the establishment of an intersectoral body with representatives from a wide range of concerned groups. Health education would not be the only concern - for, however important it might be, it represented a "soft option"; legislative action would probably be required. In reply to a parliamentary question the Minister of Health had recently stated that he was considering establishing a multisectoral body, with his colleagues from other ministries, in the coming months. That would go some way towards solving the problems of the essential multisectoral approach. The call had been made many times for "multisectoral" and "intersectoral" approaches to WHO programmes; he wondered how far such approaches were being put into practice at the national level.

Ireland's health education bureaux were running intensive programmes on alcohol consumption, which was seen as a major health education priority, second only to cigarette smoking.

Professor MATTHEIS (Federal Republic of Germany) welcomed the clear emphasis given by WHO in programmes 10.1 and 10.3 to the responsibility of the community for the psychosocial wellbeing of its members. The same philosophy was practised in the Federal Republic of Germany in a countrywide effort to improve treatment services for the mentally ill, in line with the discussions of the recent conference of European Ministers of Health. In former times mental patients were treated in large institutions, often located in remote areas. Decentralization of services, bringing the patients back to their communities, was a difficult task, and one that should be avoided by countries that were tackling such problems anew and could profit from the negative experiences of others. Repeated calls had been made by delegates for the care of the elderly within the family and the community. The care of the mentally ill should be similarly regarded.

Regarding programme 10.2, attention was drawn to the deterioration in the situation regarding alcohol and drug abuse. Several delegates, including those of Sweden and the United Kingdom, had already emphasized drug abuse as a problem for both industrialized and developing countries. She called on delegates to imagine the impact of the complete elimination of alcohol. Many beds would be freed in both psychiatric and medical wards in hospitals, and there would be many other positive economic effects. In respect of illegal
drugs, cannabis was still the one most frequently abused, followed by psychotrophic substances (amphetamines, barbiturates, etc.). Combined use of substances was becoming more common. The growing influx of cocaine was giving rise to particular concern, while abuse of heroin appeared to have stabilized, albeit at a relatively high level. In that context, she agreed with previous speakers that the proposed budget for programme 10.2 was a matter of concern. In relation to the total budget, the regular budget allocation showed an increase of only 0.01% and the overall allocation for the programme was some US$ 100 000 less than that for the financial period 1984-1985.

She welcomed the proposed activities under programme 10.2, in particular the efforts being made by WHO to control psychotrophic substances. She looked forward with interest to the forthcoming examination of barbiturates, hypnotics, and opiate agonists and antagonists. She hoped that WHO would support the efforts of the United Nations Fund for Drug Abuse Control, which was directing its attention to coca-cultivating countries in South America in a number of ways, especially by encouraging substitute crops. She supported the call for a high priority in the budget for programme 10.2.

Miss MAKHUBU (Swaziland) said her delegation supported programme 10. Although mental health was a key to development, it was a field that was often neglected. Realizing its importance, Swaziland had introduced community mental health services which were easily accessible and were integrated with maternal and child health and public health services. Such services required logistical support. Transport was a major constraint in her country, and she requested the support of WHO and other organizations in improving the situation. Construction of a new mental hospital would begin soon, to improve facilities for the mentally ill.

Swaziland had identified the need to develop qualified personnel to provide mental health services. A mental health component had been introduced into general nursing curricula, to increase the awareness of nurses of the importance of integrating mental health care with general health care. With the assistance of WHO, the United Kingdom and the United States of America, Swaziland had started a training programme for community mental health nurses, with the aim of strengthening mental health services. In training, too, transport was proving to be a constraint: there were difficulties in transporting students from training institutions to the field. Mental health was also included in the training of community health workers.

With the welcome assistance of WHO Swaziland had hosted an intercountry workshop on mental health and alcohol-related problems which had been very successful. National seminars had been conducted for traditional healers, community leaders, and health and health-related workers, to increase their awareness of mental health issues.

Dr SAVEL'EV (Union of Soviet Socialist Republics) agreed with many of the points raised by previous speakers. His delegation supported the basic orientation of programme 10. Paragraph 5 of the programme statement on programme 10.1 referred to negative psychosocial factors, including the perception of a threat from military conflicts to survival. Fear of nuclear weapons of mass destruction was having a deep psychological effect on people and hence affecting their physical condition. WHO's programme should therefore include provision for research on the negative effects of such factors on psychological development, particularly of children. The effects of the cult of strength and violence propagated through the mass-media should also be investigated.

Dr MALONE (United States of America) expressed his delegation's satisfaction at the well-defined activities presented under programme 10. As other speakers had mentioned, alcohol abuse and alcohol-related problems were a serious public health concern, reaching epidemic proportions in many areas. They were also a major cause of injuries and fatalities through accidents, particularly traffic accidents. Concerted efforts at the international and national levels were required to reduce the enormous monetary and social costs associated with those problems. Document A38/INF.DOC./4, on alcohol consumption and alcohol-related problems, submitted to the Health Assembly provided a comprehensive review of WHO's activities over recent years. He was pleased to note that significant progress had been made. His delegation was concerned about the future funding, staffing and organization of WHO's programme on alcohol, for it was not clear that adequate provision had been made in the proposed programme budget. He would welcome an answer on that point.

Dr MGENI (United Republic of Tanzania) expressed his delegation's support for programme 10.

New developments in the promotion of the mental health programme in the United Republic of Tanzania included collaboration with the Finnish Temperance Association - whose support he
acknowledged with appreciation - in training multisectoral, social and health groups with a view to educating the population on problems related to alcohol abuse and smoking.

The African Mental Health Action Group, established in response to resolution WHA30.45, was growing steadily. Membership now included nine countries and two liberation movements in east, central and southern Africa, and several other countries had expressed an interest in joining. Representatives from Member countries, at the level of minister of health, permanent secretaries and directors of health and medical services, met each year to discuss mental health programmes, to share their experiences, and to explore ways in which they might cooperate to make maximum use of their mental health resources. As its current Chairman, he expressed appreciation on behalf of the Group for the support received from WHO and other international agencies and organizations. The Group had identified several major problem areas: (1) the need to switch from centralized custodial care to community-based mental health services integrated with comprehensive primary health care delivery systems; (2) the need for community action in the control of epilepsy, a disorder which was very prevalent in many countries and caused considerable psychological distress to sufferers; (3) the need for action to contain problems posed by alcohol consumption; and (4) the need for more training in managerial and technical skills, so that health workers, workers from other sectors, and community and family members could all play a role in the promotion of mental health and the prevention of mental disorders.

Dr BATCHVAROVA (Bulgaria) said that analysis of the problem of alcohol abuse in the world had revealed an increasing proportion of alcoholics among the young and among women, and an increasing number of vehicle accidents due to drink, with the consequent economic implications. The programme had rightly emphasized the importance of preventing alcohol abuse rather than treating alcoholism as a disease, an attitude reflected in the national policy of her own country. One aspect of particular importance was the early detection of persons at risk and the devising of effective means of averting the risk - a task in which the Bulgarian Academy of Medicine was participating at the international level. In that connection there was an obvious need for a specific classification and nomenclature to be drawn up for alcoholism, and WHO had the resources and competence to do so. The issue of concise guidelines for the use of primary health care units would be most valuable in propagating a standard international doctrine on the treatment of alcoholism.

It might be possible also for WHO to take the initiative at the international level to regulate the production and sale of spirits. Similar measures in Bulgaria had resulted in a significant reduction in alcohol consumption per head of the population.

Although the problem of drug abuse was virtually of no medical or social significance in Bulgaria, an effective system of control had been devised to meet the potential threat of increased drug addiction. Bulgaria was taking an active part in international drug abuse control activities, and fully supported the current programme.

Dr PAHARI (Nepal) said that, although everyone was aware of the health hazards of alcohol, consumption continued to rise steadily. Alcohol consumption had become a part of social life, and there was little doubt that those countries that produced alcohol would continue to do so. Nevertheless, some measures could be introduced to restrict alcohol consumption, for example the imposition of a health tax on all substances constituting a health hazard, the proceeds of which could be used either by WHO or by national health authorities for the provision of essential drugs.

Drug abuse was something which reached the developing countries with development itself, and they had to be on their guard against it. He pointed out that drug abuse in both developing and developed countries tended to occur more frequently in connection with drugs in common use for medical purposes than with so-called narcotics, and he suggested that WHO might sponsor international and national meetings on that important subject.

Professor DOUKI (Tunisia) said that health for all by the year 2000 included also mental health and her delegation strongly supported the programme budget for the protection and promotion of mental health. Although it was to be hoped that the major scourges such as epidemic diseases, malnutrition etc., would have been eliminated by the year 2000, largely due to the decisive support rendered by WHO, mental morbidity was liable to increase in coming years as a result of the rapid socioeconomic and cultural changes occurring in the developing countries. Her presence as a psychiatrist in the Tunisian delegation bore witness to the practical importance attached to mental health in her country. While fully endorsing the work of WHO in that field, her delegation wished to emphasize once again the psychosocial dimension in mental health, especially in the three important fields of research, training, and prevention and treatment of mental disease. Psychological disorders could not be considered separately from their social, historical and cultural background, since
psychological factors played an important part in the etiology, semiological expression and evolution of mental disease. The cultural specificity of psychological disorders was often an obstacle to communication between psychiatrists from different countries and in the approach to the mental patient if it was based on theoretical and conceptual psychopathological and nosological models that were not specific to the case.

Therefore the first stage in any mental health strategy had to be clinical and epidemiological research, aimed at identifying the problems and the needs for staff training in the field. The promotion of mental health in developing countries had to be more than a transfer of information and health care models; the countries concerned should, on a regional basis for instance, implement specific health strategies covering many factors outside the strictly medical field, taking full advantage of the support and cooperation of WHO.

In conclusion she asked for the Tunisian delegation to be included among the sponsors of the draft resolution on maturity before childbearing and promotion of responsible parenthood.1

Dr GEORGIEVSKI (Yugoslavia) expressed his delegation's approval of the programme before the Committee. The activities under programme 10.1 (Psychosocial factors in the promotion of health and human development) showed a proper emphasis on the healthy psychosocial development of the child (paragraph 14), the prevention of psychosocial problems in vulnerable groups (paragraph 13) and the protection of population groups at risk (paragraph 15). The measures proposed for the prevention and control of alcohol and drug abuse (programme 10.2) were similar to those of the programme in his country, which would be helpful and held out promise of fruitful collaboration with WHO at regional and global levels. In March 1985 the Yugoslav Federal Assembly had adopted a special programme of drug abuse control, with particular emphasis on the role of primary health care and community involvement. His Government looked forward to close technical cooperation with WHO in the implementation of that programme.

Dr SARTORIUS (Director, Division of Mental Health) said that he and his colleagues greatly appreciated the laudatory comments by delegations and would make full use of the experienced guidance which had been provided during the debate. Any merits present in the programme derived directly from its being built up on the basis of the experience of Member States.

The majority of the observations made by delegations called for no comment. In regard to the critical question of funding, he hoped that extrabudgetary funds would continue to be made available as in the past. The Director-General would certainly have noted delegations' concern over funding and support for the programme.

Promotion of environmental health (programme 11)

Dr MARKIDES (Cyprus) said that, although Cyprus was not seriously subject to foodborne diseases apart from occasional cases of salmonellosis, his delegation attached great importance to programme 11.4 (Food safety), since so much of the food consumed at the present time was not prepared by individuals, as in the past, but by food manufacturers whose main concern was to render their products more attractive by the addition of colouring and preserving agents and other chemicals. New small-scale food manufacturing firms were coming into operation every year and it was incumbent on governments to protect the consumer and ensure that food served to the population was fit for human consumption and prepared under hygienic conditions.

The situation analysis covered most of the problems facing countries at the present time: problems of the training of staff to perform their functions satisfactorily; of the implications of the use of chemicals and pesticides; of the coordination of the different sectors of the administration concerned with food safety, and the updating and modernizing of legislation.

His delegation had noted with satisfaction the target set for programme activities and looked forward to close collaboration with WHO.

Dr ROSDAHL (Denmark) commended the excellent balance achieved throughout programme 11, which was of particular importance in that it combined aspects of concern to both developing and developed countries. The problems they faced might seem superficially different, but were essentially similar.

1 For text, see p. 132.
One example was the provision of safe and sufficient water which constituted a major public health problem in many parts of the world. In the fortunate Member States the availability of sufficient and safe water had been and still was taken almost for granted, but that situation might not continue. Chemical pollution of both ground and surface water resources was increasing in many parts of the world. To control a form of pollution which was threatening one of mankind’s most important resources, multisectoral action, involving both industry and agriculture, was needed. The experience gained in developed countries could well be useful to developing countries in drawing up their overall development strategies.

Another point of concern arose in connection with breast-feeding, the promotion of which rightly enjoyed the wholehearted support of WHO. It now appeared, however, that human milk itself was not as pure and unpolluted as might have been desired. Human fat was a reservoir for many chemicals, especially persistent organochlorine compounds, such as some pesticides, and the polychlorobiphenyls (PCB) for example, so that it was easy for those chemicals to pass into human milk. Depending on their past and present use, the substances identified and the concentrations measured varied between countries. High pesticide contents had been found in human milk in some developing countries, whereas the PCBs, which were much in evidence in some industrialized countries, had not yet been found in human milk in the developing countries, so far as he knew. Current problems in the developed world could easily spread to the developing countries if they followed uncritically the same path of development.

Dr NYATWA (Zambia) said that his delegation rated programmes 11.1 (Community water supply and sanitation) and 11.2 (Environmental health in rural and urban development and housing) very highly and supported the programme proposals.

The importance of poor water and inadequate sanitation in the transmission of disease was well known. For example, his Government had been able to stem cholera outbreaks in fishing camps in 1982–1983 by means of measures to improve rural water supply and sanitation, since when the disease had not been reported. The UNICEF/WHO joint programme review carried out in his country in 1984 had brought out the striking disparity between urban and rural areas, where water supply and sanitation were concerned. Although, countrywide, water supply coverage was 48%, urban areas accounted for some 70% and rural areas for about 30% only. Where excreta disposal facilities were concerned a similar disparity obtained, with only 5% of the population unserved in urban areas, but 39% in rural areas. Consequently, his Government was at present expanding community water supply and sanitation programmes using regular WHO and extrabudgetary funding. It was hoped that when national plans under the International Drinking Water Supply and Sanitation Decade were finalized, more funds would be available from WHO, UNDP and the World Bank intercountry programme to bring water and sanitation to the people.

Mr VOIGTLÄNDER (Federal Republic of Germany) expressed his delegation's support for programme 11.4 (Food safety) which now extended to all forms of contamination endangering human health. In that respect particular emphasis would have to be put on early identification of contaminants in the whole food production chain.

In that context attention should be drawn to the close connection between infection – such as salmonellosis – caused by food of animal origin and the zoonoses, and close coordination between the two programmes was indispensable.

Within the context of the worldwide investigation on harmful substances in food, the Central Collection and Evaluation Agency for Environmental Chemicals, as the national WHO collaborating centre, supplied relevant data from the Federal Republic of Germany suitable for international comparison. As recommended by WHO, his Government was preparing a monitoring programme in order to improve further the assessment of food contamination.

He agreed with the need to improve consumer information in matters of food hygiene (paragraph 9) and strongly supported the training of those officially responsible for food surveillance and control of foodborne infections and intoxications (paragraph 10). His country contributed to that training, inter alia, through the activities of the Institute of Veterinary Medicine, which was the FAO/WHO collaborating centre for research and training in food hygiene and zoonoses. In addition to individual further training of experts from developing countries, training courses lasting several weeks would be organized both in Berlin (West) and elsewhere, including Egypt, India, Kuwait and Pakistan. The collaborating centre also acted as directing and coordinating body of the WHO regional surveillance programme for control of foodborne infections and intoxications in Europe. The Second World Congress on Foodborne Infections and Intoxications, to be organized by the collaborating centre in 1986, was an example of the efforts being made to bring about a worldwide improvement in food hygiene and safety.
Dr LARIVIERE (Canada) expressed his delegation's firm support for programme 11.3 (Control of environmental health hazards) and endorsement of the Executive Board's recommendations, particularly those concerning chemical safety. As stated in paragraph 48 of the Board's report, chemical safety involved both the assessment and the prevention and control of risks. His delegation considered that the International Programme on Chemical Safety (IPCS) should collaborate closely and continuously with the general programme on the control of environmental health hazards. Without such collaboration in information, training, prevention and control of health hazards caused by chemical substances, the efficacy of both programmes might be endangered. His delegation also wished the Director-General to continue his negotiations with FAO with a view to its joining the other organizations participating in IPCS for the benefit of all concerned.

Referring to programme 11.4 (Food safety), he informed the Committee that a joint FAO/WHO meeting on pesticide residues had recently been held in Ottawa, and his delegation wished to congratulate the experts taking part for the excellent work that had been accomplished both at that meeting and at joint meetings over the past 25 years. The meetings, which received a substantial allocation under the WHO regular budget, were becoming increasingly important in view of the growing worldwide concern over pesticide residues and other toxic substances in food. His Government took a special interest in those joint meetings and requested ongoing support by WHO and Member States for that programme.

Professor HAVLOVIC (Austria), referring to programme 11.3 (Control of environmental health hazards) and in particular the situation regarding chemical pollution as outlined in paragraph 6 of the programme statement, said that better knowledge of the potential health risks of exposure to chemical substances would strengthen national measures to protect the population against chemical hazards. Even in the industrialized world the smaller countries were not in a position to undertake their own toxicological investigations in that field. He therefore proposed that a WHO data bank be set up to collect toxicological data on dangerous chemical compounds, giving special attention to investigations by countries with a traditionally high standard of toxicological research. Such a data bank could be used by all Member States in developing their own national preventive and control measures. While he appreciated the publication by WHO of environmental health criteria in the form of executive summaries, a data bank would cover a wider range of chemical compounds or substances.

Dr DAOUNDOU (Niger) agreed with the Executive Board that WHO should play a more decisive promotional role at country level in connection with community water supply and sanitation (programme 11.1). No doubt WHO's responsibilities in regard to the International Drinking Water Supply and Sanitation Decade should be defined more clearly, since UNDP had the lead coordinating role at country level. The financing of the Decade thus far had fallen short of his country's expectations, so that much now depended on the second phase for the achievement of the Decade's goals in Niger.

Dr HOPKINS (United States of America) expressed support for programme 11 (Promotion of environmental health).

In connection with community water supply and sanitation (programme 11.1), however, his delegation was disappointed at what appeared to be a relative neglect of WHO's role in helping countries to evaluate the impact of their water and sanitation efforts on health, and in helping them to use that information in making decisions about priorities for investment in that area. His delegation felt that the statement regarding the lead role of health authorities at national and local level (paragraph 11) should apply to WHO at the international level. Although, as his delegation was fully aware, water supply and sanitation involved a complex intersectoral effort and provision of those services was not wholly within WHO's control, such services were none the less a key component of primary health care, commanding 4.29% of the proposed regular budget for 1986-1987. Yet no disease-related targets were included, and that despite the fact that reliance on community water supply as a major component in dracunculiasis control was specifically mentioned in paragraphs 8 and 18 of the programme statement for parasitic diseases (programme 13.4). His delegation took the view that at the international level it was WHO that should be the strong advocate for water and sanitation programmes, owing to their specific health benefits; it would therefore welcome more emphasis on the health aspects of those activities.

Dr ABDULLATIF (Democratic Yemen) expressed his delegation's support for programme 11.1 (Community water supply and sanitation). Referring to paragraph 23 of the programme statement, he suggested that the proposed decrease in the provision for intercountry programmes might have to be reviewed in the light of the natural catastrophes taking place in certain African countries. Indeed the budgetary provision for the African Region needed
increasing, not merely to meet emergency needs but, as the Director-General had said in his address to the Health Assembly, to enable the programme to be used as a basis for long-term activities based on the community. While the drought problem could not be solved solely through increased allocations, it should be taken as a starting point for more active steps to improve water supply and sanitation as an essential component of primary health care. He also felt it was unjustified that the programme in the Eastern Mediterranean Region, the driest region of the world, should have its budgetary priority reduced and a corresponding decrease in its budget allocation, especially during the International Drinking Water Supply and Sanitation Decade.

Dr SAVEL'EV (Union of Soviet Socialist Republics), referring to the "problem identification and approaches for solution" for programme 11, commended the opening statement in paragraph 3, on page 158, that "environmental health problems can to some extent be correlated with the level of national socioeconomic development"; however, that theme was developed somewhat one-sidedly, from the technical point of view in particular.

In regard to programme 11.1 (Community water supply and sanitation), the proposed programme activities for the coming biennium, outlined on pages 161 to 163, included measures under the International Drinking Water Supply and Sanitation Decade, together with the mobilization of resources, further development of national institutions and technologies, development of human resources and the exchange of information but, regrettably, insufficient attention was given to the medical and health aspects of the programme, and to the integration of appropriate projects within the primary health care system. Improvements in drinking-water supply and basic sanitation were of great importance for the achievement of health for all. The proclamation of the Decade by the United Nations General Assembly should facilitate WHO action under programme 11.1. The many aspects of the problem made it difficult to solve; the success of the programme would depend, as had been stressed many times in WHO's resolutions, on close cooperation between WHO, its Member States, other international organizations such as UNICEF, UNDP and the World Bank, and the many nongovernmental organizations which supported developing countries in their efforts to provide safe drinking-water and sanitary facilities. For the future success of the programme, greater emphasis should be placed on the medical and health aspects, such as water quality assessment and field assistance to Member States in implementing the measures recommended by WHO, as also the formulation of health requirements for the treatment of industrial and agricultural effluents. The experience gained by the International Programme on Chemical Safety (IPCS) should be drawn upon for that purpose, with a view to the prevention and control of water pollution by chemical compounds in common use.

Regarding programme 11.3 (Control of environmental health hazards), he commended the work of IPCS so far, and noted in particular the progress made recently, as shown in the increased number of publications concerning environmental health criteria and the work done on the harmonization of methodologies for toxicological studies. His country's interest in IPCS was attested by the participation by many Soviet scientists in meetings held under the programme, and the series of meetings held in his country.

Inviting attention to paragraph 48 of the Board's report, he said that the close relation between risk surveillance and management of control programmes was rightly emphasized, and suggested that the training provided under IPCS should not only acquaint national personnel with risk assessment and the information contained in documents, but should also equip them to apply recommended measures at national level. The integration of those two components was also important in the elaboration of measures to be taken in medical toxicological emergencies. Member States, particularly the developing countries, should make far more extensive use of the experience acquired by IPCS in the preparation of their own programmes on chemical safety.

Professor MULLER (Netherlands), commenting on programme 11.1 (Community water supply and sanitation), said that the International Drinking Water Supply and Sanitation Decade had formulated ambitious goals for 1990, and there had been an increase in external sources of funding since the start of the Decade. However, the proposed programme budget did not provide adequate information on progress so far, and only the South-East Asia Region was mentioned as planning the preparation of a mid-Decade review by the end of 1986. He wondered whether the Health Assembly would be informed at its following session regarding the global progress, or lack of it.

His delegation would also welcome clarification on how the various United Nations organizations and bodies represented on the Steering Committee for Cooperative Action for the Decade were cooperating in practice. WHO, as the executive agency, took the lead in coordinating that complex multisectoral activity; however, in many matters, other United Nations organizations necessarily bore the primary responsibility.
His delegation would make a plea for an integrated view of the role of community participation in the rehabilitation and maintenance of water supply systems, since such participation was clearly important in all aspects of water supply and sanitation. The role of women, particularly, deserved special emphasis.

It was encouraging to see that the provision for the 1986-1987 biennium showed a substantial budgetary increase at the country level, but it was disappointing that any overall real increase was likely to be negligible. In view of the apparent substantial decrease in the budget under "Other sources", regarding which full information had not yet been available at the time of preparation of the document, his delegation wondered whether more up-to-date information, presenting a more encouraging picture, was now to hand.

Professor GIANNICO (Italy), commenting on programme 11.3 (Control of environmental health hazards), welcomed the importance given to the adverse effects of environmental pollution on human and animal health. The increasing use of chemical products in industry, agriculture, food, commerce and the domestic environment represented a danger, in view also of their presence and persistence in the environment. It was also necessary to take into account other physical pollution, such as noise and ionizing and non-ionizing radiation and the possibility of accidents in the chemical industry, as recent experience had shown. Unfortunately, it was not always easy to diagnose the resulting chronic pathology, which had its importance from the health point of view but also had social and financial repercussions.

In order to ensure the protection of populations at risk appropriate legislation was required which should extend to the utilization of chemical products. Such legislation would have to be based on international agreements, since the pollution of air and water knew no frontiers. His country accordingly supported the action taken in that regard by the European Economic Community (EEC), the Economic Commission for Europe of the United Nations, and by other intergovernmental and international bodies, including WHO. He drew attention to his country's commitment, undertaken together with other European countries, to achieve by 1993 a 30% reduction in all sulfur emissions as compared with 1980 levels. Furthermore, Italy supported the EEC policy aimed at eliminating lead from motor-fuel and at carrying out longitudinal monitoring of the quality of the environment.

It was also important to extend and improve knowledge on the adverse effects on health of exposure to chemical products and other pollutants in the environment. Existing knowledge regarding toxicity was limited to a few only of the 60 000 or so chemical substances in current use. He accordingly stressed the desirability of closer international cooperation with a view to building up a data bank on admissible chemical substances and to specifying the tolerance thresholds, as proposed by the delegate of Austria. Such objectives would obviously be difficult to achieve, since they called for very considerable deployment of human, budgetary and structural resources.

The recent publication by WHO of Guidelines for drinking-water quality, which had undoubtedly been based on considerable research and experience, was an excellent example of what could be done in the field of technical advice. Those guidelines would be extremely useful to public health administrations.1

In view of the vital importance of environmental factors on human health, his delegation supported programme 11 and hoped that the budgetary allocations for the biennium would be adequate for the implementation of the activities proposed.

Professor LA FONTAINE (Belgium), commenting on programmes 11.1 (Community water supply and sanitation), and 11.2 (Environmental health in rural and urban development and housing), believed that, where environmental protection was concerned, health care establishments and medical laboratories could well provide a better example than they did at present regarding the control of microbiological, radiological and chemical risks. All countries should exert themselves to improve the situation, which gave cause for concern. A health committee could possibly be established to consider ways and means of effecting such an improvement, both inside and outside hospitals and other installations. He also drew attention to DNA manipulations, which undoubtedly constituted a problem, although it should not be unnecessarily magnified.

Concerning programme 11.3 (Control of environmental health hazards), his delegation strongly supported the initiative taken by WHO in the field of chemical safety and welcomed the growing interest in the International Programme on Chemical Safety (IPCS). He joined previous speakers in endorsing the desirability for IPCS to deal with both the assessment and

the management of risks. That indeed concurred with the Board's position. Moreover, IPCS should necessarily be concerned with the problems of accidents and of the indispensable epidemiological surveys.

On the question of nutrition and food, under programme 11.4 (Food safety), he drew attention to the need for nutritional balance in the modern diet. Changes had taken place in feeding habits, particularly in developed countries, although the problem existed in developing countries too, arising out of the growing consumption of "fast-foods", with their excessive salt and fat content. Apart from that example, the pace of present-day living had generally affected the type of food consumed in a manner that deserved study from that point of view, as did the manner of introduction of additional vitamins in foodstuffs. There was also room for study of conservation techniques, including their repeated application to the same food, with the consequences it was easy to imagine.

His remarks were in no way intended as criticism, but rather as encouragement for the existing programme and pointers to ways in which it could be further developed within the current financial possibilities. He would also like to see it given a little more financial support.

Mrs GREAVES (Liberia) stated, with regard to programme 11.1 (Community water supply and sanitation), that, on the basis of conclusions drawn from a review of national efforts in support of the International Drinking Water Supply and Sanitation Decade, her delegation concurred with the statement, in paragraph 6 of the programme statement, to the effect that the high unit costs in some countries would seem to indicate a lack of use of appropriate technology and/or limited use of locally produced materials. Her delegation accordingly welcomed WHO's supportive activities, designed for technology development and information exchange, as a means of helping to alleviate the problem of high cost.

Liberia and other countries in the African Region were also concerned about the need to maintain existing sanitation and water systems, ensure the protection of water resources, etc. Therefore, those countries requested that WHO should give timely consideration to providing support to the African Region in those areas also, should funding become available from other sources, such as UNDP and other contributors which had not yet indicated their level of funding for 1986-1987.

Her country was most interested in collaborating, through TCCD arrangements, in the conduct of national case studies and the evaluation of community water supply and sanitation programmes, which should focus not only on the appropriateness of the technology employed, quality control, maintenance and other factors, but also on the acceptability, accessibility and ease of operation of those systems. Those were factors that obviously had an effect on their utilization, and thus on their usefulness in the control of relevant diseases.

Dr KHALID BIN SAHAN (Malaysia) expressed his delegation's strong support for the programme on promotion of environmental health, and in particular programme 11.1 (Community water supply and sanitation). It fully endorsed the programme activities for programme 11.1, which were in line with the conclusions of the international consultation on the International Drinking Water Supply and Sanitation Decade held the previous year.

His delegation had noted that, while there was an overall slight real decrease under the regular budget for 1986-1987, there would be a real increase in allocations at the country level. That increase was to be welcomed as the extra funds available would enable Member States to pursue or intensify their activities towards the programme's objectives.

Although it had been possible drastically to reduce the incidence of certain diseases through immunization, similar successes had not been achieved in respect of infectious diseases associated with poor public hygiene and water supply and with bad sanitation, such as cholera, typhoid fever, gastroenteritis, and so on, which clearly indicated the relative ineffectiveness of currently available medical technologies. The prevention of those diseases lay elsewhere, mainly in the improvement of personal hygiene and in the provision of adequate water supply and sanitation.

In that context, therefore, his delegation had noted with concern the reduced provision for 1986-1987 from extrabudgetary sources. The explanation had been given in paragraph 22 of the programme statement that the level of support from those sources had not been known when the budget was prepared. Nevertheless, it was hoped that the final level of contributions from those sources, particularly UNDP, would be much higher than indicated.

He referred to the important role played by regional centres for the provision of environmental programmes, such as the Regional Centre for the Promotion of Environmental Planning and Applied Studies (PEPAS) in the Western Pacific Region, in facilitating and supporting regional and country level programmes. He hoped that those centres would continue to receive adequate support. His delegation welcomed the increasing number of activities,
particularly training, taking place at PEPAS, as well as the posting of a Decade engineer to the Centre, and had noted with satisfaction that the post of Director of the Centre would soon be filled. Periodic monitoring of that programme was necessary, and he was glad to note that the item would be included in the agenda of the forthcoming session of the Regional Committee for the Western Pacific. His country was grateful to the Regional Director for the support extended to that Centre and for giving the programme due priority.

The meeting rose at 17h25.
NINTH MEETING
Wednesday, 15 May 1985, at 9h00
Chairman: Dr A. AL-SAIF (Kuwait)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1986-1987: Item 22 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II) (continued)

PROGRAMME POLICY MATTERS: Item 22.2 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II, Chapter II) (continued)

Health science and technology - health promotion and care (Appropriation Section 3; Documents PB/86-87, pages 106-199; EB75/1985/REC/1, Part II, Chapter II, paragraphs 37-56; A38/INF.DOC./3; A38/INF.DOC./7; and A38/INF.DOC./11) (continued)

Promotion of environmental health (programme II) (continued)

Dr UNSAL (Turkey) said that his delegation strongly supported the proposed programmes on the promotion of environmental health.

Although a high level of socioeconomic development did not exclude the possibility of health problems originating in the environment, the extent of such problems was likely to be much greater in developing countries because economic projects were implemented without prior investigation or any appreciation of their environmental impact.

The resurgence of malaria in Turkey in 1977, for example, was the consequence of failure to remain on guard against the disease after its eradication from the country. The consequent shortage of personnel with experience in the field of malaria had left Turkey unprepared for that resurgence, which was probably caused by the environmental changes resulting from the construction of a dam on the Seyhan River in the south of the country for irrigation and energy production purposes. The possible side-effects of the expansion of irrigation and drainage systems and arable lands had not been taken into consideration in time. In that most developed and richest part of Turkey, the number of cases of malaria had reached 101 000 in 1977, only seven years after its eradication. He therefore stressed the importance of environmental impact assessment before economic projects were implemented, so as to avoid the adverse effects of environmental changes on human health.

An international workshop on environmental health impact assessment, supported by the WHO Regional Office for Europe with the collaboration of the University of Aberdeen (United Kingdom), had been organized in his country by the Ministry of Health and Social Assistance in 1985. Some 40 high-level personnel from different sectors related to the environment, such as ministries of agriculture, of energy and natural resources, state water undertakings, meteorology, etc., had participated in the workshop. All the participants had stressed the need for training courses in the subject and had expressed their thanks, to which he added his own, to all those who had provided help and made contributions to the workshop. He hoped that WHO would consider organizing and supporting similar courses in several developing countries.

Turkey was still experiencing considerable problems in providing water supplies and sanitation, especially in rural and periurban areas. The needs of the rapidly increasing population in the towns and cities, resulting from migration from rural areas, could not be met in time. As a result, morbidity from diarrhoeal diseases was still high. The Ministry of Health and Social Assistance had therefore decided to accelerate the distribution of oral rehydration salts, while the Government was trying to expand water supply and sanitation projects. Health education and health personnel training programmes had been strengthened through collaboration between the Turkish radio and television authorities and the Ministry of National Education, helped by contributions from WHO, UNICEF and UNFPA.

With regard to food safety, Turkey was endeavouring to strengthen its national food control programmes and food safety management. Revision of the regulations on food specifications had almost been completed by a group composed of representatives of the Ministry of Health and Social Assistance, the Ministry of Agriculture, the universities and
various branches of the Chamber of Commerce. It was expected that consumers would participate in food safety activities after the implementation of health education programmes in that area.

Professor FORGACS (Hungary) expressed his delegation's approval of, and support for the programme on community water supply and sanitation (programme 11.1). His country attached particular importance to the programme activities described in paragraphs 16 and 20 of the programme statement, entitled "Development of national institutions" and "Technology development and information exchange". In Hungary, the quality of drinking-water had been successfully controlled since 1955 but increasing contamination of water sources necessitated more frequent and expanded testing which would, in turn, require modernization of the instrumentation in the public health laboratories. In 1961, legislative measures had been introduced to protect water resources against contamination.

With regard to environmental health in rural and urban development and housing (programme 11.2), he informed the Committee that during the past 20 years enormous efforts had been made in Hungary to improve housing. One-third of the total population had moved into new dwellings during that period. That had required extensive research to determine the influence of the new environment on the health of people living in those new, industrially-constructed housing projects and residential areas. Hungary was therefore participating in the European study on public health aspects of housing, coordinated by the Regional Office for Europe, to which there was an allusion in paragraph 18 of the programme statement.

Hungary also supported the objectives of programme 11.3 (Control of environmental health hazards) and had participated in studies concerned with the hazards to the environment created by pesticides, cadmium and lead, as well as by aluminium processing plants. It would greatly facilitate national work in that field if WHO could contribute to the further development of relevant institutions.

Dr KLIVAROVA (Czechoslovakia) said that her delegation, as in the past, strongly supported programme 11 on the promotion of environmental health.

Czechoslovakia was especially interested in questions connected with the scientific study of the effects of chemical substances and physical factors and radiation on the environment, on human beings, and on animals and plants. It was particularly interested in programme 11.3 (Control of environmental health hazards), and was participating in the International Programme on Chemical Safety (IPCS), in which it had assumed responsibility for the study of the effects of acrylonitrile, and had passed on to WHO the results of its investigations on that substance. The Institute of Hygiene and Epidemiology in Prague had organized a number of meetings in connection with that programme, the last having been held in April of the current year. Czechoslovakia was interested in research on scientific methodology for determining the effects of chemical substances on health as well as in the results of those studies in terms of both short- and long-term effects.

Once the degree of hazard of a chemical substance had been determined, the next stage was to develop criteria concerning maximum permissible concentrations. Her country had developed such standards for the atmosphere, for the air in industrial undertakings, for drinking-water and effluents, for soil, and for pesticide residues in foodstuffs. Thus the results of scientific research in that sector were being applied.

Dr KYELEM (Burkina Faso) said that, as a result of the drought which had persisted in his country for over 10 years, he was particularly interested in programme 11.1 (Community water supply and sanitation). Water had become a scarce commodity in Burkina Faso, both in towns and in rural areas. According to 1983 estimates, only 24% of the rural population had reasonable access to drinking-water and the figure for towns did not exceed 35%.

The national water programme for villages, undertaken in 1984, had led to the drilling of 1000 new wells. Efforts would continue, aimed at providing 25 litres per person per day in towns and 10 litres per person per day in rural areas by 1990. His country was benefiting from support by the international community in the framework of the International Drinking Water Supply and Sanitation Decade, for which it was grateful. It hoped that such help would continue. In order to preserve water quality, sanitation measures were needed in the area around water supply sources; for that purpose, his country would appreciate technical help from WHO, especially in the training of sanitary personnel, who were in short supply.

Dr BATCHVAROVA (Bulgaria) expressed her delegation's full support for the programmes included under the promotion of environmental health. Through the Academy of Medicine Bulgaria was cooperating with WHO on problems in that area, and would continue to do so.

Her only comment referred to the budgetary allocations for programme 11.3 (Control of environmental health hazards) on page 173 of the programme budget. She noted that no resources from the regular budget were allocated to Europe for country programmes and that the resources foreseen from other sources were nearly four times smaller than in the current budgetary period. Significant problems were facing the European Region in that area, and solving them would require adequate financing.

Dr SCHEUERER (Switzerland) said that his delegation noted with satisfaction the attention paid by WHO to community water supply and sanitation (programme 11.1) and approved the increase in funding for that important sector of public health.

Intersectoral cooperation was rightly stated in paragraph 11 of the programme statement to be indispensable, but that cooperation should not be limited to the national level, to which that paragraph referred, but should also involve the activities of WHO itself. There should also be close coordination between the activities of WHO and those of UNICEF, which was deeply committed, and he was surprised that no mention of that organization was made in the programme statement. The same comment applied to the World Bank.

Experience and evaluation of the results obtained showed not only that inappropriate technologies, materials and methods had been chosen but also that installations had not always been properly maintained; the latter was often a weak point in community water supply and sanitation programmes. In many cases, such maintenance should be carried out, if not by the community itself, then at least under its supervision. Paragraph 20 of the programme statement did allude to that point, but only in respect of certain regions. He was surprised, therefore, that that aspect was not reflected in the programme for the African Region, where maintenance posed a real problem.

His delegation noted with satisfaction the reference in paragraphs 18 and 19 to social and community aspects and to behavioural factors. It welcomed the decision to convene a scientific group to consider those matters, since it could not be denied that a number of community water supply and sanitation programmes had not produced the desired results, and not only as a result of technological problems, just as inadequacies in maintenance were not always attributable to construction methods or management weaknesses. Because of social problems or sociological factors, some families were denied access to water supplies or continued to use polluted water at the same time as clean well water. He could cite many other cases where, despite the installation of proper facilities, hardly any improvement in health had resulted.

He endorsed the remarks made by the delegate of the Netherlands regarding the need to pay greater attention to community participation. He hoped that WHO would continue to follow up and evaluate the results of community water supply and sanitation programmes, especially with regard to their effects on health. He also hoped that WHO would help Member States to carry out such follow-up action at the national level.

Mr MARTIN-BOUYER (France) said that environmental problems and their impact on health constituted one of the most complex problems which had to be resolved in the years to come. The unprecedented development of the chemical industry with the introduction of new molecules in every aspect of daily life was already creating great difficulties and it was to be expected that it would become one of the major problems of the 21st century. One example was the intensive use of fertilizers, which had made possible a great increase in agricultural production but posed the threat of pollution of underground water supplies by nitrates.

He placed particular emphasis on programme 11.3 (Control of environmental health hazards) and especially on IPCS. His country in recent years had had to cope with a series of accidents, such as the poisoning of several hundred infants through accidental contact with hexachlorophene, resulting in 34 deaths, and the poisoning by bismuth of some 1000 people, of whom 70 died. The concentration of the production of non-ferrous metals such as lead and cadmium, in particular in northern France, had resulted in serious problems. There had also been the case of the clandestine transport and storage of 41 drums of toxic waste with a high dioxin content following the disaster at Seveso, Italy, and the fire in a transformer in France which had also produced dioxin. His country therefore greatly appreciated the activities of IPCS in evaluating the toxicity of various substances and the publication of guidelines.

A scientific symposium, in which 17 countries were taking part, was currently starting in France, with the object of evaluating the different tests for mutagenicity and carcinogenicity that showed his country's interest in such activities.
In addition to such evaluations, essential as they were, it was important to initiate preventive and intervention activities under the programme and, in that connection, he would like to make two proposals: the setting-up on the initiative of WHO firstly of a rapid intervention group able to respond to appeals for help from countries faced by new and urgent toxicity problems that they were unable to deal with, and, secondly, in cooperation with the World Federation of Associations of Clinical Toxicology Centers and Poison Control Centers, of poison control centres in those countries and regions where they did not currently exist. In the light of all those considerations, he wished to associate himself with other delegates regarding the programme, and especially the delegates of Italy, Belgium, Austria and Bulgaria. With them he wondered what could be done to strengthen the programme, in terms of both budgetary resources and of personnel.

Dr BISHT (India) said that, while his delegation supported the programmes under discussion, he wished to point out that the International Drinking Water Supply and Sanitation Decade placed the responsibility for providing safe drinking-water and sanitary facilities on the shoulders of governments; that was a heavy burden for his country, where there were some 600,000 villages. His country had scored many successes, as shown by the evaluation programme which was currently functioning smoothly after initial difficulties, but it had also suffered some setbacks, since there were still about 100,000 "problem villages". One of the lessons learnt in his country was that the provision of water and sanitary facilities had to be backed up by a vigorous mass education programme, aimed at making the people aware of the need to maintain installations properly and of the existence of water-borne diseases. Otherwise, the supply of water could lead to an increase in such diseases.

With regard to environmental health and the disaster which had occurred in his country at Bhopal, he said that that disaster had shown up the complete lack of information, not only about the finished product, but also about the intermediates used in the manufacture of pesticides. Thanks to the efforts of physicians and local and national authorities and the assistance of WHO and friendly countries, India had managed to contain the disaster. Nevertheless, there was a continuing need to follow up the treatment of the victims over a long period.

He felt that WHO and its regional offices had a clear responsibility, not only for the preparation and setting-up of a data bank, to which countries suffering a similar disaster in the future could refer, but also for the drawing-up of appropriate laws on chemical safety and for devising effective monitoring systems. While responsibility for providing full information on the raw materials and intermediates used in the manufacturing process, as well as on the finished product itself, especially in the case of dangerous and hazardous chemicals, rested with the chemical companies concerned, some system or machinery was required to ensure that that information would be made available in time of need, even if some trade secret was involved. The interests of humanity should prevail and WHO had a clear responsibility to explore that subject.

Dr MAGNUSSON (Iceland) said that his country, which depended on fishing for 70% of its national income, was increasingly concerned about the current tendency to use the seas and oceans as dumping grounds for chemicals and nuclear waste. His delegation therefore also felt that too little attention was given to that matter in the programme on the control of environmental health hazards (programme 11.3). Oil dumping was referred to in paragraph 5 of the programme statement, while paragraph 12 pointed out that marine pollution was a matter of direct public health concern. However, he would like to know whether any specific measures would be taken within the programme to study the environmental and health consequences of the continued dumping of chemicals and nuclear waste into the seas and oceans, which were a valuable source of proteins and other essential nutritional elements.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) said that his delegation supported the idea of a rapid intervention group as proposed by the delegate of France; the Bhopal tragedy had shown the need for such a group. His delegation also supported the second proposal made by the delegate of France, namely the setting-up of poison information centres. It was his understanding that such centres would be coordinated on a worldwide basis. For some time his country had had a network of such centres, open 24 hours a day and provided with a data base on common chemicals which could cause poisoning. Any doctor could apply for advice and assistance to any centre.

Dr DIETERICH (Director, Division of Environmental Health) thanked delegates for their support, information, advice and guidance, which would all be very valuable in planning and implementing activities during 1986-1987, and would help in pursuing those already planned.
He also thanked many Member States for making their expertise and institutions available and for supporting the Organization's drive to improve health through environmental action by including such action in their national programmes.

In particular, he acknowledged five points dealing with the principles and policies of programme development which the Committee had put forward to guide the Organization.

The first point was that the programme needed to address itself to both the communicable and noncommunicable diseases associated with unsatisfactory conditions in the environment. A balance had to be struck in that respect. It was clear that, in addition to the old problems, with which the Organization had been grappling since its inception, the new problem of biological, chemical and physical pollutants in air, water and food was now affecting all Member States and had to be of concern to the programme for the promotion of environmental health, particularly in its research activities. In future, that part of the programme would no doubt need additional resources. A new approach was being developed to address the main problems in the developing countries, and help fund the necessary activities, including cooperation to develop appropriate legislation, standards and regulations, which in turn called for the active involvement of health authorities and the ready availability and application of scientific information on health risks. It also included cooperation in the establishment of assessment capabilities, such as monitoring procedures, laboratories, environmental health impact assessments, poison centres and responses to emergencies, as well as cooperation in the development of appropriate manpower and the promotion of intersectoral coordination.

Secondly, several delegates had insisted that the work in environmental health should be integrated with primary health care, particularly in relation to the safety of food and drinking-water supply and sanitation. That principle was well understood and was guiding the planning and implementation of the programme. He referred to the review undertaken the previous October by the Executive Board's Programme Committee on water supply and sanitation in relation to primary health care. That review had been based on a report by the Director-General containing a full analysis not only of the need for integration but also of the progress that had been made (document EB75/PC/WP/2). The Secretariat would be pleased to make the relevant document available to all delegates. The report also covered the progress of the International Drinking Water Supply and Sanitation Decade, about which some delegates had inquired. The Decade was moving forward, but too slowly, and the national health authorities were not always playing their role.

Thirdly, it was acknowledged that water must be not only available but safe. That was a primary concern of WHO, but even more fundamental was the principle that the availability of water supply and sanitation could not be the privilege of the people who could afford to pay for it. That was why WHO was so actively involved in the International Decade; there had to be more emphasis on serving the underserved, such as the rural and urban fringe populations, and on sanitation. The target continued to be access for all people to safe drinking-water and sanitation in adequate quality and quantity. Perhaps it could be agreed that that target was the health aspect of the Decade and should therefore be the Organization's main objective. If, for example, at a time when the World Bank was advocating full cost recovery even for drinking-water in villages, WHO were to concern itself only with, say, drinking-water standards, hundreds of millions of people would be left without drinking-water and sanitation and therefore without primary health care. That had also been strongly emphasized in the report of the Programme Committee of the Executive Board, along with the promotional, institutional, social, manpower and resources mobilization aspects involved.

The fourth point related to the need to look at the improvement of environmental health as a long-term effort while at the same time being selective in orienting the programme towards health issues. Several delegates had spoken on the matter, and he thought that the principle was well recognized in the implementation of the programme.

The fifth point concerned the balance between the two basic thrusts in the programme: the efforts to build up capability in national programmes and the international evaluation of progress and the dissemination of information thereon to Member States. A good example of that balanced approach could be found in the programme for the control of environmental health hazards and in the area of drinking-water quality and its surveillance.

Finally, the Committee had provided guidance on coordination within the Organization and with other international, multilateral and bilateral agencies, with development banks and among the national agencies involved in environmental matters.

**Diagnostic, therapeutic and rehabilitative technology** (programme 12)

Dr ABDULLATIF (Democratic Yemen) said that his delegation strongly supported the programme. He complimented the Organization on the achievements so far in developing countries, such as his own, which was working towards 90% coverage of the population by 1990
with essential drugs at different levels of care, from the voluntary health guide at community level with his or her ten essential drugs starting in 1980, through the rural health unit with its 35 items to the rural health centre with its 60 essential drugs. Those three together formed what was called the basic and community health care level.

However, his delegation felt that certain areas of great importance and relevance to the essential drugs policy had not been emphasized. One was the possibility of establishing at regional level studies of small-scale drug industries, particularly those concerned with oral rehydration therapy. That was in line with technical and economic cooperation between developing countries and at the same time with securing the supply of essential drugs at regional level. His delegation also felt that some emphasis should be placed on strengthening the work of the regional offices in respect of essential drugs.

Professor FORGACS (Hungary) said that the efforts made by the Director-General to promote the concept of lists of essential drugs were highly appreciated by his Government. The adoption of that concept by many Member States, the progress achieved in a limited number of countries and the opportunities outlined in the situation analysis for programme 12.2, paragraph 10, were the first indications of the success of the Action Programme on Essential Drugs and Vaccines. The programme activities planned for 1986-1987 were realistic, and he supported the general idea that they would focus essentially on activities at country level. If other organizations of the United Nations system were involved in the Action Programme, its efficiency could be increased, and cooperation with organizations like UNIDO and UNDP should be strengthened for that purpose.

Dr FERNANDO (Sri Lanka) said that essential drugs and vaccines were an integral part of all national strategies for health for all based on primary health care, but the national drug policies in several cases had still not been able to ensure that essential drugs were available to all. That could be due to lack of budgetary resources, which was understandable, but every so often it was further complicated by the need to purchase sophisticated drugs to the exclusion of essential ones.

Drug policies were often affected by commercial factors, so that medical practitioners were induced to use drugs not on the essential list in the absence of any genuine indication for such use. The quantity and quality of essential drugs that a country could purchase depended on the resources available and the cost of the drugs concerned. At no stage should the quality of a drug be considered as being secondary to its price. Thus, what developing countries wanted was an economic and reliable supply of essential drugs, or for that matter of any drug. It was well known that high quality drugs were acquired most economically through pool buying; once again he made a plea to WHO to organize the pool buying of essential drugs for those developing countries which hoped to participate in such buying.

Drug quality was closely connected with drug policies; countries such as his own could not afford to undertake extensive quality control of all drugs that they purchased; there was thus another field for WHO collaboration in the setting up of control laboratories to help such countries. WHO could also help by indicating those manufacturers who observed good manufacturing practices and by blacklisting those who did not.

Finally, he mentioned that for economic reasons his country still used goat-brain vaccine for rabies, although such use was obviously undesirable. He therefore requested WHO to explore all possible means of obtaining improved vaccines at prices that developing countries could afford. Since cold chains were hard to maintain in remote parts of developing countries, WHO should also actively look into the production of heat-stable vaccines for use in basic immunization.

Dr TIDJANI (Togo) noted with satisfaction the special attention given by the Executive Board to programme 12.2 (Essential drugs and vaccines). The Government of Togo had made great efforts for several years in that area by developing, over the entire country, an efficient network of permanent centres for essential drugs and vaccines. As an example, the state pharmacy, Togo Pharma, provided a regular supply of a certain number of drugs and vaccines at an affordable price throughout Togo. Some useful practices involving traditional medicines should be integrated, if possible, into his country's primary health care system. His country would like increased cooperation in the future with WHO, on the one hand to help it make safe and efficient essential drugs and vaccines permanently available and on the other to speed up the development of a cold chain for better vaccine storage.

Dr NYAYWA (Zambia) said that his delegation supported programme 12.2 (Essential drugs and vaccines). The need for drugs in his country had increased owing to the implementation of the primary health care programme, and its extension to the community level had increased
the demand still further. However, problems of procurement and distribution at health centre and community level had made communities reluctant to support the health workers and had caused some of them to resign. His country was, therefore, particularly anxious to take advantage of the activities outlined in paragraphs 9 and 10 of the programme statement.

His delegation supported the target laid down in programme 12.3 (Drug and vaccine quality, safety and efficacy), namely to enable most countries to develop means of monitoring and maintaining the quality, safety and efficacy of drugs and vaccines by 1989. All too often, developing countries were used as a dumping ground for ineffective medicines. However, the sum of US$ 70 000 allocated from the regular budget to country activities in the African Region was inadequate to achieve the targets outlined in the programme. Further extrabudgetary resources should be found if possible.

Mrs ODUORI (Kenya) said that her delegation also supported programme 12.2 (Essential drugs and vaccines). All Government dispensaries and health centres in rural areas received a regular supply of essential drugs and vaccines through the programme, and its effectiveness and reliability had been amply proved. Her country was grateful for the support afforded by WHO and friendly Member States. Her delegation considered that nongovernmental organizations could also benefit from the programme, and should be given assistance, especially in such areas as essential equipment and transport. The rural population could be confident of finding the medicines they needed even in small local health centres, and that confidence had encouraged rural patients to use them. The same mechanism of drug supply was now being considered for district hospitals.

Mr WORNELL (Canada) said that his delegation supported programme 12.5 (Rehabilitation) and welcomed the provision of greater attention and resources for the disabled. However, he wondered whether the disabled themselves had been consulted in the planning, development and implementation of the programme at an international and regional level. United Nations General Assembly resolution 37/53 (1982) entitled "Implementation of the World Programme of Action concerning Disabled Persons", in paragraph 15, requested WHO, in the light of the experience of the International Year of Disabled Persons, to review its definitions of impairment, disability and handicap in consultation with organizations of disabled persons and other appropriate bodies. What action had been taken by the Organization to implement the resolution and what mechanisms for consultation with organizations of the disabled had been established for the review of the definitions?

Dr MURRAY (Grenada), referring to programme 12.3 (Drug and vaccine quality, safety and efficacy), said that her delegation welcomed the facilities for quality control of rabies vaccines and sera at the regional level mentioned in paragraph 20 of the programme statement.

Turning to programme 12.2 (Essential drugs and vaccines), she endorsed the comments of the delegate of Sri Lanka concerning the difficulties of rabies control in developing countries. Owing to the high cost of animal and human vaccination programmes, her country, like other developing countries, did not have the funds to vaccinate dogs and other animals against rabies, and WHO might give more attention to that problem. More research was also needed into the epidemiology of rabies, particularly in respect of specific animal vectors.

Dr WILLIAMS (Sierra Leone), referring to programme 12.4 (Traditional medicine), said that traditional medicine was extensively practised in her country, especially since only 35% of the population had access to centralized modern health services. However, so far, only traditional birth attendants had been integrated into the primary health care programme. The next step was to organize other practitioners of traditional medicine into official associations. WHO's assistance would be most welcome in the identification and classification of medicinal plants and traditional medical beliefs and customs. Scientifically-trained health workers should be given experience of traditional medicine, which had been able to satisfy people's needs in ways which modern medicine could not. Although the budget allocation for the programme had been increased, the large number of proposed activities might make additional funds necessary: in that event, the Director-General might use his good offices to obtain extrabudgetary resources.

Dr BOB'OYONO (Cameroon) said that his delegation appreciated the commitment of WHO to primary health care, which was one of the main ways of achieving health for all by the year 2000. Primary health care must be supplemented by secondary and tertiary services which could meet the increased demand resulting from progress at the primary level. As the Minister of Health of his country had said, in plenary session, Cameroon's health policy combined the gradual introduction of health units of a high standard with a determined commitment to primary health care. However, the human and financial resources needed to
implement such a policy remained a problem and in the current economic crisis short-term measures were essential. His delegation supported the ambitious programme 12.1 (Clinical, laboratory and radiological technology for health systems based on primary health care) but wished to propose the provision of mobile dispensaries as an interim measure. Such dispensaries would provide basic surgery and anaesthesia, vaccination, radiological facilities, and case-finding and treatment of endemic diseases. Some health units of that type on the market used solar energy, an abundant but insufficiently utilized form of power. His delegation proposed that a few mobile dispensaries should be tried out in various countries, and adopted on a wider scale if they were found to be cost-effective. They might prove useful in providing health care to nomadic populations.

Dr NJINJOH (Cameroon), referring to programme 12.4 (Traditional medicine), said that his country recognized the vital role of traditional medicine in achieving health for all. Cameroon would welcome the collaboration of WHO in developing national policy and legislation on traditional medicine. The wide publicity given to traditional medicine in recent years and the soaring cost of living had led to the proliferation of "native doctors". The vast majority, however, were nothing but quacks, charging exorbitant fees, demanding payment before treatment and prescribing cure-all concoctions. If no measures were taken against them, traditional medicine would lose its credibility and its role in primary health care. There was an urgent need for national policy and legislation, and his country welcomed the proposed pooling of experience by means of newsletters and workshops, as outlined in paragraph 14 of the programme statement. However, it was unfortunate that no budget allocation had been made to the African Region for traditional medicine at the intercountry and regional level, since extrabudgetary sources were unreliable.

Professor ROUX (representative of the Executive Board) recalled that the Executive Board had approved the establishment of a revolving fund, administered by UNICEF, for the procurement through UNICEF of essential drugs and vaccines. The Board was aware of the difficulties experienced by many developing countries in obtaining the drugs and vaccines required in good time. The new fund should help to overcome those difficulties, but the proposal required more detailed elaboration and implementation, including initial funding.

The meeting rose at 10h35.
TENTH MEETING
Wednesday, 15 May 1985, at 14h30
Chairman: Dr D. G. MAKUTO (Zimbabwe)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1986-1987: Item 22 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II) (continued)

PROGRAMME POLICY MATTERS: Item 22.2 of the Agenda (Documents PB/86-87, and EB75/1985/REC/1, Part II, Chapter II) (continued)

Health science and technology - health promotion and care (Appropriation Section 3; Documents PB/86-87, pages 106-199; EB75/1985/REC/1, Part II, Chapter II, paragraphs 37-56; A38/INF.DOC./3; A38/INF.DOC./7; and A38/INF.DOC./11) (continued)

Diagnostic, therapeutic and rehabilitative technology (programme 12) (continued)

Mr MECHE (Ethiopia) said that the importance of essential drugs and vaccines in primary health care was well known. His delegation fully supported the programme activities, proposed under programme 12.2 (Essential drugs and vaccines) to accelerate the promotion of the Action Programme on Essential Drugs and Vaccines in order to enable Member States to provide a regular supply of essential drugs and vaccines to their people.

Ethiopia had formulated a national drug policy some years earlier, and since then had established a national list of drugs and a list of essential drugs, and had identified those essential drugs to be handled at various levels of the health system. A workshop had been held two months previously to finalize that work. Implementation had started with the organization of in-service training for existing health workers. Future training curricula for the various categories of health workers would be adapted to incorporate a component on essential drugs and vaccines.

WHO's efforts were clearly directed at improving the procurement and distribution of essential drugs and vaccines; it should lay more emphasis on support to Member States in developing their own production, as that was the best means of making them self-sufficient in the long term.

Dr LIU Xirong (China) said that traditional medicine had a history of several thousand years, and a rich store of both theoretical and practical experience had been accumulated in the treatment of many diseases. It was continuing to play an important role in the maintenance of human health and was highly valued among the people of many countries. Such a rich heritage should be maintained and developed by means of exchanges of experience among Member States and other methods. He therefore supported the policies outlined for programme 12.4 (Traditional medicine), which aimed at encouraging and supporting the integration of the practice of traditional medicine into national health systems based on primary health care. There was a growing interest in the utilization of traditional medicine and local resources to implement primary health care programmes in many Member States, especially the developing countries - a most encouraging development.

China had always attached great importance to traditional medicine, and its hospitals actively funded its development. There were over 1200 hospitals, with 87 000 beds, devoted entirely to traditional medicine. China currently had 320 000 traditional medical staff, and schools for training at all levels had been set up. There were also numerous traditional medicine research institutions, and many books and periodicals were published on the subject. A Chinese traditional medicine journal was published in English to facilitate exchanges with other Member States. Traditional medicine had made an enormous contribution to the strength and prosperity of China; traditional medicine and pharmacological centres welcomed opportunities for exchange of experience and collaboration with corresponding centres in other countries.
In recent years WHO had undertaken a great deal of work in the field of traditional medicine, including the conducting of studies, the setting-up of collaborating centres, and the compiling of information on the most commonly used herbs, providing guidance for their classification, utilization, preparation and quality control. Meetings had been convened on the integration of traditional medicine with primary health care. In the Western Pacific Region, several international training courses in acupuncture and conferences on the development of standard acupuncture nomenclature had been held. China was collaborating with WHO in the organization of an interregional seminar on the role of traditional medicine in primary health care, to be held in China in October 1985.

He expressed the hope that WHO would pay greater attention to traditional medicine in the future, providing increased support in the form of both financial resources and manpower. He was convinced that traditional medical care would play a key role in the achievement of the goal of health for all by the year 2000.

Professor LAFONTAINE (Belgium), expressing his delegation's support for programme 12 as a whole, said that laboratories were an essential element in the delivery of primary health care. A distinction had to be made between the situation prevailing in industrialized countries and that in the developing countries. The former needed to reappraise and rationalize their use of technologies in order to make optimum use of resources. The latter needed to develop simplified but efficient laboratories using inexpensive equipment that was cheap to run and reagents that were freely available; the analyses they undertook should be chosen with care and with due regard to their efficacy and reliability, and WHO's efforts in that regard deserved full support; the tests they carried out should relate to individual clinical diagnosis, epidemiological work, and environmental monitoring, including water control.

With regard to the introduction of new radiological technology, again a distinction should be made between the situation prevailing in industrialized countries and that in developing countries. The latter needed to provide basic equipment that could be easily maintained and was available in sufficient quantities for use in primary health care. The industrialized countries should take care to introduce new diagnostic and therapeutic technology rationally and without undue haste, balancing the advantages and disadvantages of the old and the new. He supported the development of technology that could be used in care in the home, for example in renal dialysis, thereby reducing demands for hospital care. Such technology might also ultimately play a role in the surveillance at home of the sick, the handicapped and the elderly.

Dr MIGUES (Uruguay) was pleased to note the emphasis given by the Executive Board to programme 12.1 (Clinical, laboratory and radiological technology for health systems based on primary health care) since, as it took shape, it would meet one of the real needs of developing countries. They were doing everything possible to establish health systems based on criteria of regionalization, levels of care and scales of complexity. The greatest problem encountered was lack of clinical laboratory and radiological technology suited for use in a primary health care system. It was important that those technologies should be available not only in hospitals, but especially in a network of outpatient health care centres with a proper system of referral where they could reduce the pressure on hospitals and ensure the best possible use of the funds available. The Executive Board had rightly focused its attention on the identification and adaptation of those technologies for that purpose.

He was concerned to note that the 1986-1987 regular budget allocations for the Region of the Americas under programme 12.1 showed a reduction of some 24% for country activities and some 86% for intercountry and regional activities compared with those for 1984-1985. The reductions were even greater if the extrabudgetary funds assigned in the Region were taken into account. He would welcome an explanation.

Professor BA (Senegal) commended the efforts made by WHO in helping Member States to implement effective measures for the quality control of drugs. However, there was still a great deal to be done. Quality control was required after storage and transport: drugs were frequently formulated in a way that necessitated storage under specific conditions, and storage and transport conditions were often far harsher than those utilized in stability tests. Although some manufacturers were already taking that fact into account, it was far from the general rule. Further, the majority of those responsible for drug transport had received neither the training nor the information required to enable them to take the necessary precautionary measures. Quality control was particularly important for the expanded programme on immunization, in which difficulties with the cold-chain were common,
and very often there were no arrangements for determining the efficacy of vaccines immediately prior to use. He stressed the need for the support of WHO and other organizations to accelerate the establishment of national and local quality control laboratories which could also be used for the quality control of food and water.

His delegation supported programme 12, the implementation of which would bring nearer the attainment of the objective of health for all through a rational use of effective and safe products obtained at the lowest possible cost.

Mr SAMSOM (Netherlands), referring to programme 12.1, endorsed the view expressed in paragraph 11 of the programme statement regarding the prevalence of unnecessary radiological examinations in the industrialized countries. The European Economic Community had recently adopted a directive concerning the protection of patients against the harmful effects of ionizing radiation applied in the diagnostic procedures. In his own country, a special unit had been established within the Ministry of Welfare, Health and Cultural Affairs to promote the safety of medical X-ray installations and diagnostic procedures used. He looked forward with interest to the implementation of the activities specified regarding quality assurance and more effective use of techniques (paragraph 19).

The Netherlands had a two-fold interest in programme 12.2 (Essential drugs and vaccines). It was seeking opportunities to assist developing countries, primarily on a bilateral basis, in the implementation of national policies. In that connection, he reported that since the Thirty-seventh World Health Assembly the Netherlands had decided to support the programme with two associate experts, funded from its development cooperation budget. The Netherlands was also collaborating with WHO with a view to developing an integrated approach at country level to improve both government drug control and the drug distribution and production systems, in particular for the public sector. Lasting effects of any efforts on the part of WHO and its Member States would only be achieved if sound national infrastructures were provided. Professional education facilities at university level would be essential to generate the necessary expertise and manpower for deployment both in control systems and in systems for drug distribution and production.

The Netherlands was also interested in the Action Programme on Essential Drugs and Vaccines in connection with its own domestic situation. The rational use of drugs was becoming an issue of active policy interest, with both the utilization of drugs and the economic aspects of procurement and use coming under increasing scrutiny. A study was being conducted with a view to stimulating the generic prescribing of drugs. The Government had concluded a basic agreement with the social sickness insurance funds and the medical and pharmaceutical societies, with a view to achieving a reasonable cost-benefit approach to the prescribing and dispensing of drugs destined for use in the public sector (covering about 70% of the population). A pilot project had been designed for the development of a consulting service in clinical pharmacology for general practitioners. A post had been established within the above-mentioned ministry for the development of a system to assess the therapeutic value of drugs in relation to their cost. His country was monitoring international activities with interest to see whether comparable approaches were developed elsewhere.

He welcomed the Director-General's report (document A38/INF.DOC.3) explaining the respective functions of the programme on drug and vaccine quality, safety and efficacy and the Action Programme on Essential Drugs and Vaccines. It was clear that the functional relationships between the two programmes were multiple and close.

The priority of those two global programmes and their continuing expansion were of such importance that it had become necessary to consider whether the interests of WHO and its Member States might not be served best by centralizing all currently available manpower and financial resources within WHO headquarters. Against the background of zero budgetary growth, such a move would provide clear advantages both from the financial point of view and as regards the optimal deployment of the expert manpower available. In that way, the high priority assigned to that field by the Director-General and the Health Assembly would be clearly demonstrated.

His remarks in no way detracted from his delegation's general support for both the Action Programme on Essential Drugs and Vaccines and the programme on drug and vaccine quality, safety and efficacy. They were the best that could be achieved under the circumstances and those concerned were to be commended.

Professor Roux, the representative of the Executive Board, had referred to the establishment of a revolving fund under joint UNICEF/WHO management. His own delegation supported the idea of setting up such a fund, but noted that during the relevant discussion at the seventy-fifth session of the Executive Board - only four months previously - no detailed information had been available regarding its possible structure, as it had been under study by UNICEF and WHO. The proposal to set up such a fund had nevertheless been
adopted. He would welcome further information regarding the present situation, and asked whether a report would be submitted to the Thirty-ninth World Health Assembly to permit detailed discussion.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) expressed his delegation's satisfaction with the continuing progress of programme 12 in general and, in particular, the initiatives taken in many countries in connection with essential drugs and vaccines (programme 12.2); although there was a small decrease in the proposed allocation to the programme for 1986-1987, he understood that its continued implementation would not be affected by that decrease. The chief delegate of the United Kingdom, when confirming in plenary session wholehearted support for the programme, had officially announced that the United Kingdom would be providing an additional £200 000 for the Action Programme on Essential Drugs and Vaccines for 1985. His delegation also welcomed the progress made with preparations for the forthcoming conference of experts on the rational use of drugs, although the response from Member States which had voted overwhelmingly in favour of resolution WHA37.33 in 1984 had been disappointing. The United Kingdom, which had been one of the first countries to provide financial support for the meeting, was very pleased to hear that Dr Kaprio, the former Regional Director for Europe, would be playing such an important part.

Delegates would be interested to hear that the Association of the British Pharmaceutical Industry had agreed to spend up to £250 000 on two projects related to the programme, the first in conjunction with UNICEF in the Maldives, and the second in Africa. The Maldives project was concerned with the establishment of two mobile floating laboratory dispensaries travelling between islands, providing primary health care and facilitating the distribution of pharmaceuticals, especially those requiring cold storage. The African project, to be implemented in cooperation with the African Medical and Research Foundation International, aimed to extend the scope of some very useful work carried out by the Kenyan Government by improving facilities for the transport of medical products and circulating rational information on drug usage. The project would take advantage of some of the excellent flying doctor facilities in that part of East Africa. Both projects should yield valuable information for the future.

The need for further technical information on pharmaceuticals had been discussed at the Thirty-seventh World Health Assembly in 1984. The Pharmaceutical Society of Great Britain had distributed free of charge to national health administrations throughout the world copies of the Martindale Extra Pharmacopoeia, an extremely comprehensive monograph on drugs which included also information on side-effects, overdoses, poisoning, etc. His Government had also supplied copies of the British National Formulary to those interested, and had recently agreed to reprint copies of the Prescriber's Journal. Also in regard to documentation, the Organization was to be commended on the excellent summary of the relationship between the Action Programme on Essential Drugs and Vaccines and the programme on drug and vaccine quality, safety and efficacy (document A38/INF.DOC./3), and on Technical Report Series, No. 704, 1984, a report of the WHO Expert Committee on Specifications for Pharmaceutical Preparations, which deserved to be widely read.

Progress with programme 12.3 (Drug and vaccine quality, safety and efficacy) had been satisfactory, although some of the targets appeared optimistic. While recognizing the importance of full cooperation with the United Nations Secretariat, it was perhaps open to question whether the consolidated list of products, referred to in paragraph 14 of the programme statement, should not have been prepared by WHO, as the organization primarily responsible for action to be taken reporting drug withdrawals and hazards from drugs. He would like to hear the views of the Organization on that point. Reference was made in paragraph 4 to the WHO certification scheme on the quality of pharmaceutical products moving in international commerce; that was a most important scheme which should be adopted by more countries. It was disturbing to find how many people were unaware of the scheme, and strenuous efforts should be made to disseminate information on it. In conclusion, he was pleased to note that continued funding would be available for the four collaborating centres for biological standards.

Dr WESTERHOLM (Sweden) welcomed the progress made on programmes 12.2 and 12.3. It was essential that those programmes be extended to cover more countries. It was a matter of satisfaction that the conference of experts on the rational use of drugs was to be held in November 1985 in Nairobi; the results and recommendations should be presented to the Health Assembly in 1986.
Dr CANITROT (Argentina), referring to paragraph 3 under programme 12.2, said that it was true that many countries were still without an adequate pharmaceutical policy not only for primary health care but also for the health system as a whole. In his own country the legislative foundation had been laid in 1965 but had been brought to nought by the actions of successive military administrations from 1966 onwards.

It was also true that current procedures for the procurement and supply of essential drugs and vaccines needed to be improved, but in connection with procurement reference should also have been made to the price factor. In that respect the programme statement did not go far enough; the costs of licensing drugs and assigning trade marks in Latin America, for example, were well above internationally accepted levels. Overcharging for imported drugs by pharmaceutical manufacturers and suppliers was a major problem in the health services of developing countries. In 1983 Argentina had paid US$ 220 million for medical drug imports, a figure which had been estimated to be US$ 80 million over the international reference price. He would like to see WHO set up an international network that would inform on and register prices for drugs and medical supplies in order to combat overcharging, as had been done on the regional basis in Latin America, where Argentina, Brazil, Chile and Mexico had also concluded agreements on the production of essential drugs. The main concern of those countries was not so much with procurement and supply but with the drawing up of an integrated policy by agreement between the health, industrial and commercial interests concerned on all aspects of the drug problem - innovation, production, commercialization, supply and use of drugs - a policy covering not only the administrative supply but also the pharmacochemical aspects. Pharmaceutical manufacturers, on the other hand, often appeared more concerned with expanding their markets and increasing their profits than with meeting the needs of the population.

Argentina had drawn up a national formulary which included 250 essential drugs and similar action had been taken in Brazil and Mexico. Formularies of that type were intended not only as a vademecum in procurement and supply, but also to bring order into the countries' own production and sales policy. That was where international aid was required not only from WHO and international organizations, but also from all other bodies concerned with the serious question of drug supply, which accounted for almost 40% of total health expenditure in Argentina, so as to arrive at a policy which was not solely concerned with procurement and supply. While he fully supported the other aspects of programme 12, he would like to see the proposals under programme 12.2 revised on the lines he had indicated so as to provide the type of integral policy on drugs which the developing world required.

Dr BROTO WASISTO (Indonesia) said that drugs and vaccines played a strategic role in health care in both urban and rural areas. Unfortunately the availability and quality of drugs in many developing countries were sometimes very disappointing. In Indonesia about 96% of all drugs and vaccines were produced within the country, but 95% of the raw materials still had to be imported. The price of drugs in Indonesia was relatively high in relation to the socioeconomic status of the population. Most of the essential drugs were produced by government pharmaceutical companies to ensure correct pricing, availability and regular supply and distribution. One of the big problems facing the Government was the low acceptance of the essential drugs concept by the medical profession, in particular specialists in the larger hospitals.

In addition to the activities included in the programme, his delegation wished to put forward the following proposals for consideration: the drawing-up of guidelines for good manufacturing practice for drug production, the establishment of national and regional referral laboratories for drug quality control, research to improve acceptance of the essential drugs concept by the medical profession, and the provision of technical assistance in the production of raw materials. He supported the proposal for a revolving fund for the procurement of essential drugs, but also stressed the need for regional depots to ensure proper distribution.

Miss NIELSEN (Denmark) was very pleased to note that the concept of essential drugs had gained widespread acceptance, resulting in accelerated implementation of the programme at country level. During its few years of existence the Action Programme on Essential Drugs and Vaccines had established itself as a very dynamic programme. Denmark's bilateral experience and collaboration both with WHO and UNICEF had demonstrated WHO's great efficiency both in providing the necessary technical back-up and assisting countries in drawing up and establishing their own essential drugs programmes, and in formulating global policies and strategies. Coordination between the Action Programme and other relevant programmes (such as the Expanded Programme on Immunization) was good, and it was clear that even greater emphasis
was to be placed on the "optimal use of resources" in the future. One aspect to be considered was the division of labour between UNICEF and WHO in the field of essential drugs, where it was clear that the two organizations had complementary roles to play. She commended the close cooperation and coordination with UNICEF and with bilateral donors.

Her delegation fully endorsed the programme activities for 1986-1987 as outlined in the programme budget. The planned activities showed clearly that the programme had been the catalyst for the movement from a phase of general international awareness and acceptance of the concept to the phase of actual implementation of agreed policies. In view of the strong support for the programme expressed at the Thirty-seventh World Health Assembly and the importance which WHO itself attached to the programme, it was a little surprising to find a decrease in the total allocations from the regular budget. The reference to increased extrabudgetary resources in paragraph 27 did not justify a reduction in the allocations from the regular budget. Her delegation therefore welcomed the statement by the representative of the Executive Board that the Action Programme should be given priority for additional financing from the Director-General's Development Programme.

Her delegation fully supported the establishment of a revolving fund for the procurement of essential drugs as recommended by the Executive Board, but she would like to have more details in regard to the modalities of the fund. It was her understanding that, although for practical and formal reasons the fund would have to be set up by UNICEF, its management and administration would be a joint UNICEF/WHO responsibility.

Dr KYELEM (Burkina Faso) said that his delegation supported programme 12 as a whole, and took particular interest in programmes 12.2 (Essential drugs and vaccines), 12.3 (Drug and vaccine quality, safety and efficacy) and 12.4 (Traditional medicine). In his country over 5000 million CFA francs were spent annually on expensive imported drugs. The national drug policy attached great importance to the availability, quality, safety and efficacy of drugs, as well as to their cost, since the public at large, whose means were limited, must be able to afford essential drugs. Another important aspect was to sensitize medical practitioners, who should have confidence in the essential drugs. He supported the initiative for the establishment of a revolving fund with a view to supporting national policies on essential drugs in developing countries.

He expressed gratitude to the Government of Italy which, through UNICEF and WHO, would be supporting a programme on essential drugs in his country from 1986 to 1988.

Dr MGEMI (United Republic of Tanzania) said that his delegation gave its full support to all activities proposed under programme 12.2 (Essential drugs and vaccines). It was gratifying to note that due recognition had been given to the collaborative role of various United Nations bodies, governments and nongovernmental organizations, since it was through full participation of all parties concerned that the meagre resources available could be utilized to the full, and certain negative practices could be exposed and eliminated. His delegation would like to see that collaboration further strengthened during the biennium and, in accordance with paragraph 22 of the programme statement, extended to all the parties concerned, including other competent United Nations organizations. Such collaboration would be in conformity with recent resolutions adopted by the Health Assembly, particularly paragraph 4(6) of resolution WHA37.17 and paragraph 6 of resolution WHA35.27. It further hoped that the conference of experts scheduled for 1985 in accordance with paragraph 2(3) of resolution WHA37.33 would foster the necessary coordination among the parties involved.

Dr HAJAR (Yemen), expressing support for programme 12 as a whole, said that activities under programme 12.1 (Clinical, laboratory and radiological technology for health systems based on primary health care) had begun in his country in the 1960s, and a review of the relevant services had been carried out in 1984. As a result, activities had been redirected towards primary health care, were less centralized, and had witnessed a shift in emphasis towards therapeutic activities. A new training component had been included in the curricula of the College of Science, and in 1984 a new training department had been opened at the Faculty of Medicine and Health Sciences. The result had been an increased number of trained personnel.

In regard to radiological technology, a unit had been set up under the Ministry of Health to monitor radiological hazards, and work had commenced on equipping health units and centres with basic radiological facilities.

Regarding essential drugs and vaccines (programme 12.2), there had been a radical change in policy with the passing of new legislation on the registering of essential drugs. Work was now proceeding on limiting the number of drugs and he hoped that it would be brought to a successful conclusion with the assistance of WHO.
Regarding rehabilitation (programme 12.5), a centre equipped with up-to-date facilities had been established in Yemen. There was, however, an urgent need for training, and it was hoped that WHO could provide expertise to assist in raising the level of performance.

Dr SULAIMAN (Nigeria) said that his delegation noted with satisfaction the continued development of the programme on traditional medicine (programme 12.4) and fully supported it. Further action was called for by WHO to establish the scientific as well as the traditional basis for such practices in order to guarantee their safety and effectiveness. The number and variety of traditional practices in different countries and cultures called for specific WHO guidelines to enhance their integration within primary health care. The information activities on traditional medicine (paragraph 11 of the programme statement) should be expanded to take account of broad guidelines on the recognition of traditional practices.

Closely related to that issue was the concept of "alternative medicine". In many countries parallel medical practices were developing, though their scientific basis was often doubtful. Those with a sound scientific basis, such as acupuncture, chiropractic, osteopathy and homeopathy should be integrated into the mainstream of health care, and the complementary nature of all medical practices should be emphasized. Again, a systematic study and set of guidelines were required from WHO to assist Member States, especially the developing countries.

Mr MARTIN-BOUYER (France) expressed his delegation's support for the proposed activities under programme 12. It approved the approach proposed under programme 12.1 (Clinical, laboratory and radiological technology for health systems based on primary health care) to identify laboratory techniques most suited to primary health care. That was equally applicable to the industrialized countries, where laboratory examinations were often prescribed repeatedly without sufficient explanation or benefit to the patient. He therefore welcomed the proposal in paragraph 13 to improve the cost-effectiveness of existing laboratory services and promote networks of small, low-cost laboratories. That presupposed, however, good quality control of laboratory tests, failing which the laboratories would lose their credibility and effectiveness. The establishment of such a network should not be at variance with the development of new methods or technologies which in the long term might prove more effective and profitable. France was prepared to continue to assist in the training or further training of laboratory technicians, both for conducting tests and for maintaining equipment.

In regard to the programme on essential drugs and vaccines (programme 12.2), he said that, while the bold concept of essential drugs had gained acceptance among scientists and national decision-makers, it now required a shift in emphasis on the part of the pharmaceutical industry away from the development of consumption, on which it had so far based its activities, towards production and distribution in which criteria of effectiveness, cost and reliability would predominate. It also presupposed a new attitude on the part of the general public, who should see drugs not as a panacea imported from elsewhere, but as an integral part of national primary health care.

France fully supported the new approach, as testified by the assistance provided to various countries under bilateral cooperation for national programmes on essential drugs and vaccines. An international course on drug management had been held, and would be repeated, at the National School of Health in Rennes. Contacts had been made and would be pursued with French pharmaceutical industries to assist them in formulating and implementing the new policy for drug and vaccine production, control and distribution.

His delegation therefore welcomed the initiative to set up a revolving fund to assist countries in making essential drugs and vaccines available to the public.

Dr OLFIELD (Gambia), referring to programme 12.1, joined other delegates in emphasizing the need for simple, basic laboratories. He deplored the fact that, while sophisticated laboratory equipment existed on the market, the simple, low-cost equipment of the kind so often needed was still not available.

Regarding essential drugs and vaccines (programme 12.2), one of the most important recent developments was action aimed at improving management and logistics at country level; that had made for a more efficient utilization of resources and better distribution and availability of essential drugs in developing countries. In his view, the programme on essential drugs and vaccines lent itself to the use of microcomputers; ways should be sought of introducing them into the management of drug supplies.

A problem in connection with essential drugs was the fact that some technical cooperation programmes were aimed at increasing the quantity of drugs. Donations of drugs might lead to a sense of false security in countries which would ultimately have to face the problem of financing the drug supplies themselves. Attention should therefore be given to the question of finding ways for countries to purchase essential drugs.
Referring to programme 12.4 (Traditional medicine), he said that the problem was to place traditional medicine on a sound scientific basis. Since countries did not appear to be able or willing to study objectively the status of traditional medicine, he welcomed the programme objective of identifying those practices that were safe and effective.

Mrs FERRERO DE BARRIOS (Venezuela) welcomed the activities proposed under programme 12, which were of particular importance for developing countries. She emphasized the need for the closest possible cooperation between WHO, the beneficiary governments and other organizations active in that field.

In that context and with reference in particular to programme 12.2 (Essential drugs and vaccines), her delegation wished to emphasize the advantage that WHO could derive from collaboration in that field with the other organizations of the United Nations system and the organizations involved, as pointed out in paragraph 7 of the programme statement and by previous speakers. That comment was particularly relevant in view of the conference of experts to be held in Nairobi in November 1985 that would discuss the pharmaceutical industry and the marketing, production, and distribution of drugs.

Dr RAHAMAN (Bangladesh) stated, in connection with programme 12.2 (Essential drugs and vaccines), that in view of his country's large population and dwindling resources his Government had taken a bold step in restricting the availability of drugs to those that were essential. All drugs known to be harmful had been banned, and those with no proven efficacy had been removed from the list of drugs allowed to be manufactured in the country. Incentives had been provided to national manufacturers so that they could compete with the multinational companies. While the latter were still in Bangladesh and continuing to manufacture, the results achieved by that measure so far had been promising, and essential drugs were now available at a reasonable price.

Prevention of childhood diseases through the Expanded Programme on Immunization was another major thrust of his Government's programme, and he was gratified that, with the assistance of WHO, Bangladesh had been able to take steps towards self-sufficiency in the production of essential vaccines. That objective had already been met in respect of the manufacture of tetanus toxoid, and his country would soon be able also to manufacture diphtheria toxoid. It was intended that other vaccines should follow soon. He also stressed the vital importance of the maintenance of cold chains, and expressed his gratitude to WHO and UNICEF for their assistance in making that equipment available to primary health care centres. His country was also grateful to DANIDA and SIDA for their help.

Dr BISHT (India) expressed his delegation's full support for programme 12 (Diagnostic, therapeutic and rehabilitative technology). Under programme 12.1 (Clinical, laboratory and radiological technology for health systems based on primary health care), he wished to stress the need for greater cost-effectiveness and care in avoiding unnecessary clinical tests.

Programme 12.2 (Essential drugs and vaccines) was extremely important and deserved full support. He expected that the forthcoming conference of experts on the rational use of drugs, to be held in Nairobi later in 1985, would result in recommendations of value to governments, industry and consumers, and that the schemes for procurement of essential drugs could lead to considerable savings and release of resources for other health programmes. His own country was fortunate in that it was able to produce most essential drugs, and it was ready to cooperate fully in making them available.

With regard to programme 12.3 (Drug and vaccine quality, safety and efficacy) and to paragraph 14 of the programme statement in particular, he stated that his Government had fully supported the compilation by the United Nations of a consolidated list of products which had been banned or restricted within countries. WHO should continue to collaborate fully with the United Nations in that effort, along with other agencies such as FAO and UNIDO. Referring to paragraph 15 on biological products, his country would welcome increasingly active involvement by WHO in the field of genetic engineering technology and closer collaboration with agencies such as UNIDO and FAO in the field of recombinant DNA technology. That technology was a field where considerable research was going on, particularly in industry, with a view to producing vaccines, as well as for diagnosis and treatment of diseases. India was particularly concerned that the relevant technology and its applications should be accessible on reasonable terms to developing countries. His Government had earmarked substantial funds and provided host facilities for setting up an international centre for genetic engineering and biotechnology in India, which could concentrate on health applications.
Where programme 12.4 (Traditional medicine) was concerned, India, like many other developing countries, believed that better use could be made of resources in traditional medicine to meet the needs of primary health care. In India there were a large number of institutions of traditional medicine and persons engaged in the practice of those systems, and separate councils existed to ensure standards of education. What was necessary within those systems was more extensive and improved quality control of traditional medicines, which, while ensuring their quality, would at the same time maintain their low costs. His delegation therefore fully supported the activities proposed under programme 12.4 for 1986-1987.

Dr HASSOUN (Iraq) expressed his country's appreciation to WHO for the efforts being made by the Organization in respect of the quality, safety and efficacy of drugs and vaccines, under programme 12.3.

At the present time, Iraq was producing 70% of the drugs it needed through a pharmaceutical company under the direction of the Ministry of Health, but it was obliged to import substantial quantities of raw materials. Pharmaceutical laboratories made every effort to ensure quality control, and he stressed the need for competent staff in that regard. He welcomed the help being given by United Nations organizations to reinforce that action.

Dr MARUPING (Lesotho), commenting on programme 12.4 (Traditional medicine), stated that traditional healers had been officially recognized in her country since the early 1970s and their registration was the responsibility of the Ministry of Health. In recent years, increasing efforts had been made to work closely with them within the framework of primary health care, and traditional healers had participated in all primary health care seminars organized at district level. The aim of those meetings was to orientate both government and special groups relevant to primary health care and to identify their role in its implementation.

Within the training of primary health care workers, some traditional healers, selected by their communities, had been trained as village health workers, and most of those healers welcomed the opportunity for that dialogue. They were trusted in the community and showed enthusiasm in collaborating with local health workers. Concern about "quacks", while legitimate, could after all apply to both traditional healing and modern medical practice. The organized associations of traditional healers had shown great strictness in proposing only the properly qualified among their colleagues for registration. Healers themselves were concerned about any "quacks" in their profession, and had indicated their desire for government support in dealing with that problem.

In March 1985, with WHO support, a meeting of traditional healers had been held, which had also been attended by appropriate government officials, including the Solicitor-General who had made a significant contribution. It had emerged that existing legislation was restrictive and gave the impression that it aimed at stopping or preventing the practice of traditional healing; a consensus had been reached for a review of such legislation. It had also become apparent that traditional healers saw their profession as a "precious gift of God to be used for the benefit of the people". Accordingly, the question of the ethics governing all health workers had fallen on receptive ears. The meeting had also emphasized the need for local medicinal plants to be protected and preserved, and for studies to be undertaken thereon.

The interest and enthusiasm with which the traditional healers had discussed such primary health care activities as oral rehydration therapy, immunization, and promotion of breast-feeding had been gratifying. If that spirit were sustained the traditional healers would represent another very valuable sector of human resources working towards health for all. Follow-up action should be planned, with the assistance of WHO, and her delegation accordingly requested the Director-General to strengthen the budgetary support for that programme.

Mr FEKIH (Tunisia) referred to the difficulties which his country had experienced in applying an essential drugs policy. In the first place, a certain reticence had been noted among the medical profession which did not appreciate the point of limiting the number of products put at their disposal; it related to the inadequate means of developing countries
for countering, or at least supervising, the advertisements put out by the multinational companies through their representatives. Quality control laboratories were virtually non-existent, so that developing countries were in a weaker position when seeking to obtain the most favourable prices on the basis of international competition. Difficulties also existed in respect of efforts to pool procurement as among several countries in the same region, due to their different nomenclatures and purchasing procedures and different technical means of quality control, since pool procurement required a common position in all those respects for negotiating with the suppliers who had their own requirements.

Local production of essential drugs in the developing countries was encountering many obstacles due to lack of up-to-date technology and insufficient cadres of competent personnel for production and control. That raised the problem of transfer of technology and supply of raw materials which was also difficult to solve in view of the reluctance shown by suppliers of raw materials, who, moreover, at the same time possessed all the requisite technology.

His delegation would therefore urge that WHO should take certain measures to make the essential drugs policy effective. The Organization should assist developing countries in training qualified personnel for production and quality control, and should help those countries in setting up control laboratories; that would enable them to purchase drugs of proven efficacy at the best possible prices. WHO should also promote a dialogue between developing and industrialized countries, so that the latter would agree to transfer their technology, at a reasonable price, to the countries which were in need of such technology and which would undertake to institute local production of drugs within the framework of a policy on essential drugs. In addition, WHO should draw up a code of good practices in drug advertising as it had already done for the manufacture of drugs and for the marketing of breast-milk substitutes.

Mrs MAKHWADE (Botswana) stated, in respect of programme 12.5 (Rehabilitation) that her delegation attached great importance both to the prevention of disability and to the rehabilitation of the disabled.

It was estimated that 10% of the population in Botswana had some degree of disability. Since the expense and impracticability of institution-based rehabilitation was well known, her country had fully embraced the concept of community-based rehabilitation (paragraph 7), and believed that, with families and communities playing a full part, the disabled had a better chance of leading fulfilled lives. WHO, together with international and local nongovernmental organizations, such as the national Red Cross, had supported that endeavour in the past. Indeed, the WHO manual on community-based rehabilitation had first been field tested in Botswana, with such success that it was now being translated into the local language.

Her Government welcomed the fact that WHO would be addressing itself to the training of rehabilitation workers (paragraph 11), since there were very few institutions in Africa and worldwide which provided adequate training in that area, and consequently WHO's input was badly needed.

The funds allocated to rehabilitation of the disabled for 1986-1987 were rather small, and her delegation would urge WHO to seek to mobilize extrabudgetary resources to support country programmes when needed.

Dr BORGÔNO (representative of the Executive Board), replying to a point raised in the discussion, said that, while the concept of a revolving fund for essential drugs and vaccines was an extremely good idea in itself, it should be borne in mind that the operation of such a revolving fund was a far from easy task. For instance the fund would require an initial capital of some US$ 10 to 20 million and countries would be required to supply information for tenders and bidding and to reimburse the fund on specified dates. Its operation would therefore call for real commitment by governments. That had been the experience with the revolving fund for vaccines in the Region of the Americas.

Dr KAPRIO (Executive Secretary, Conference of experts on the rational use of drugs) recalled that the discussions on the WHO Action Programme on Essential Drugs at the Thirty-seventh World Health Assembly had led to the adoption of resolution WHA37.33 on the rational use of drugs, which had requested the Director-General: to continue to develop activities at national, regional and global levels 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; and 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 rational use of drugs, in particular through improved knowledge and flow of information, and to discuss the role of
marketing practices in that respect, especially in developing countries. The
Director-General had also been requested to submit a report on the result of the meeting and the implementation of that resolution to the Thirty-ninth World Health Assembly.

In November 1984, the Director-General had consulted the Executive Board Ad Hoc Committee on Drug Policies concerning the organization of the conference, and the Ad Hoc Committee had formulated a series of recommendations, including an agenda and a list of working papers, which were reported to the seventy-fifth session of the Executive Board. On the basis of those recommendations, a number of decisions had been taken by the Director-General and action had been initiated.

The Government of Kenya had agreed to act as host to the conference of experts on the rational use of drugs, which would be held from 25 to 29 November 1985. The choice of Kenya as a possible location had been governed by the fact that it was one of the countries with a well-developed countrywide essential drugs programme, supported by WHO and some important bilateral agencies. Preparations were proceeding, and a field visit would be arranged during the conference to enable participants to see some of the health facilities in Kenya and the operation of the essential drugs programme.

The agenda would relate to sources, types and availability of information; drug control and distribution; marketing practices; training, education and other information transfer; and the Director-General's oral summation of the issues and proceedings, and their implications for WHO's programme. The recommendations of the conference would serve as background for the development of the Director-General's report to the Thirty-ninth World Health Assembly. Ten working papers, in the six official languages, would be presented, and no other documents would be distributed during the conference. The working papers would be reviewed, in order to ensure objectivity, by a peer review group, consisting of Dr Grímsson (Iceland), Dr Koinange (Kenya) and Dr Morrison (Canada), meeting from 22 to 24 July. Participants would receive the documentation in early October.

In line with the recommendations of the Board’s Ad Hoc Committee, the number of expert participants invited was being restricted to 100. Those experts, who were being invited in their individual capacity, were being drawn from a broad spectrum, i.e. from governments and national drug regulatory authorities, as well as from industry, consumers' and patients' rights organizations, health care providers, teachers and economists, as well as experts from the United Nations agencies and nongovernmental organizations concerned. Former and new members of the Board's Ad Hoc Committee on Drug Policies would be invited to attend, as would the peer review group and the authors of the working papers.

He expressed appreciation for the positive cooperation received from all groups contacted with the aim of identifying the best possible expertise for the conference. It was expected that invitations would be issued in early June.

With regard to financial support, he wished, on behalf of the Director-General, to thank the Governments of Denmark, Finland, Italy, Malta, Norway, Sweden and the United Kingdom, which had responded generously to the Director-General's appeal for funds. So far approximately US$ 200,000 had been pledged. However, there was still a shortfall and negotiations were continuing with Member States. Since the conference was to be convened in 1985, in accordance with resolution WHA37.33, the Director-General had made it possible to use funds from uncommitted voluntary sources to bridge the gap and enable preparations to go ahead. No funds would be diverted from the regular budget for purposes of the conference.

He would be available for discussions during the rest of the session.

Dr LAURIDSEN (Action Programme on Essential Drugs and Vaccines) expressed appreciation for the comments made.

He outlined the present procedures undertaken in cooperation between WHO and UNICEF in respect of essential drugs, and which provided for quality analysis of products. Certain problems had arisen in connection with oral rehydration salts, to which a number of delegations had referred. In fact, more than 40 countries were producing oral rehydration salts and intravenous fluids locally. A technical and financial mission had visited Democratic Yemen to enquire into feasibility of national production, and a similar visit had been made to Ethiopia where production was planned for 1986.

Four Regional Offices had been strengthened by field officers almost exclusively concerned with essential drugs programmes at the country level. There was now worldwide collaboration on the programme, with UNICEF as WHO’s closest partner under an agreement established a number of years previously, but WHO also worked with UNIDO and, to a lesser extent, with UNDP and the World Bank; the pharmaceutical industry was also involved and, in addition to the Association of the British Pharmaceutical Industry, three other national associations were supporting country schemes for quality control, distribution, and training.
of staff. As some delegates had mentioned, the largest scale collaboration was with bilateral development agencies, whose contribution in terms of money and impact was clearly very important. Pool procurement on a large scale had so far not been successful, and it was believed that many developing countries would benefit from pooling in the countries themselves, where procurement was currently fragmented among various sectors. It was hoped that UNICEF’s procurement policies would help a number of countries to obtain better prices and larger quantities of good quality drugs; a representative of UNICEF hoped to give a brief explanation of his organization’s procedures in that connection. In reply to a question raised by the delegate of Sri Lanka, WHO and UNICEF provided indicative prices of drugs on request and sent lists of reputable suppliers to countries which had difficulty in obtaining good prices; but a black list of suppliers fell beyond the scope of the programme. The question of vaccines had been discussed with UNICEF and the Expanded Programme on Immunization, and it was believed that the present procedure, under which UNICEF procured the vaccines and WHO ensured quality control, gave very satisfactory results in terms of prices and quality.

In connection with the collaboration of nongovernmental organizations in the programme, the Churches of Kenya, the Ministry of Health of that country and WHO had agreed on an integrated plan for a mission of organizations concerned with essential drugs. Kenya provided a very important example of technical cooperation among developing countries (TCDC), since all its neighbouring countries now had essential drugs programmes at various levels of implementation.

Where budgetary problems were concerned, the decrease in allocations shown on page 188 of the programme budget was illusory and was in fact mostly due to adjustment for compliance with the zero growth budget; the allocations should be compared with those of 1984–1985, which showed a considerable increase over earlier budgets. The financial situation was brighter than the actual figures showed, particularly since the Director-General would be contributing US$ 350 000 to a country programme and the position as regards extrabudgetary resources showed a considerable improvement over 1984–1985 with the United Kingdom contribution of £200 000 now added. The complex questions raised by the delegate of Argentina with regard to budget policies could not be dealt with in a meeting of Committee A.

The Action Programme was working closely with other WHO programmes and with the Gambia on the management and improvement of the distribution system, including the possible application of microcomputer technology for that purpose. In all the programmes to which WHO lent advice, stress was laid on the need for long-term financial arrangements, cost recovery systems, local revolving funds, drug cooperatives and so forth, but there was no way in which the Action Programme could solve the currency exchange problems with which developing countries were confronted.

The delegate of Tunisia had mentioned the reluctance of physicians and other health workers to accept limited lists of drugs: WHO’s experience showed that over a reasonably short period, when good quality essential drugs were supplied on a regular basis, health workers came to appreciate operating with reasonably limited lists. The Action Programme was working with a number of universities and pharmaceutical schools with a view to including the concept of essential drugs in the training of physicians, pharmacists and health workers.

Mr GOODALL (United Nations Children’s Fund) said that the UNICEF Executive Board, at its meeting in April 1985, had approved the recommendation that US$ 23 million should be raised by UNICEF to facilitate the procurement of essential drugs for developing countries, as many delegations were already aware. The matter had also been discussed at the Thirty-seventh World Health Assembly in 1984 and at the seventy-fifth session of the WHO Executive Board in 1985. US$ 3 million, which was a specific requirement, was intended to cover activities other than drug procurement, since distribution within countries and the logistic problems involved in distribution had also to be dealt with. One of the main problems in the supply of drugs to rural areas was their transportation from the port of entry or the capital to those areas. The training of health workers in the use of essential drugs was also a vital need and there were other important factors such as the accurate assessment of drug requirements based on epidemiological information and the compilation of national lists of essential drugs. UNICEF and WHO were collaborating closely in providing support to governments in that field, as was recognized in the UNICEF/WHO Joint Committee on Health Policy, and all those matters would be discussed between the two secretariats on a day-to-day basis.

The delegations of the Netherlands and Denmark had requested further information on the modalities of the scheme for the procurement of essential drugs. Written information on that subject was being prepared and would be sent to potential donor governments and distributed
UNICEF would be circulating shortly a revised list of indicative prices, based on the prices paid by UNICEF for about 120 essential drugs on the world market. Since UNICEF purchased drugs to the value of some US$ 20 million annually, the procurement division was in a position to obtain very attractive prices, so that the information in the indicative price list was of considerable use to ministries of health.

Dr SANKARAN (Director, Division of Diagnostic, Therapeutic and Rehabilitative Technology) referred to programme 12.3 (Drug and vaccine quality, safety and efficacy) and to the need for independent quality control laboratories, mentioned by the delegate of Sri Lanka and others, to ensure that foreign manufacturers were using manufacturing practices in conformity with WHO recommendations. WHO attached the greatest importance to all aspects of quality control and particularly to the needs of the developing countries in that connection. The Executive Board, at its seventy-fifth session, had welcomed the twenty-ninth report of the WHO Expert Committee on Specifications for Pharmaceutical Preparations,¹ which contained a detailed, costed plan for a small control laboratory. Although that was described as a minimum facility, it could bring an important measure of self-reliance in drug control within the reach of virtually every country. Assurance that good manufacturing practices were complied with was a basic element of the WHO certification scheme on the quality of pharmaceutical products moving in international commerce. Nearly all the major drug exporting countries were among the 107 Member States participating in that scheme, which would be one of the topics of interest at the forthcoming conference of experts on the rational use of drugs to be held in Nairobi. WHO had commissioned accelerated stability testing of all the substances in its model list of essential drugs, together with a series of simple tests to detect gross degradation. That information would shortly be issued as a compendium to provide practical guidance for Member States on storage requirements for those substances. He was glad to be able to reassure the delegate of the United Kingdom with regard to the United Nations consolidated list of products banned, severely restricted or not approved: a memorandum of understanding had been signed recently by the Director-General of WHO and the Secretary-General of the United Nations, assigning to WHO full responsibility for information concerning the pharmaceutical products on the list and all communications with Member States in that connection.

With regard to rabies vaccine, WHO headquarters had provided guidance and expertise to a country in South-East Asia with a view to producing rabies vaccines in cell cultures for both human and veterinary use. The newly acquired technology would then be transferred to neighbouring countries. The question concerning campaigns for eradicating stray dogs and wildlife reservoirs of the rabies virus and a question regarding DNA technology could best be answered later in the discussions on communicable diseases. With regard to quality control of vaccines (paragraph 20 of the statement for programme 12.3) and the reference to national laboratories of two countries in the South-East Asia Region, those countries were Indonesia and Thailand, and the laboratories were essentially involved in the control of the quality of vaccines for the Expanded Programme on Immunization.

Turning to programme 12.1 (Clinical, laboratory and radiological technology for health systems based on primary health care), he expressed his gratitude to the delegate of Cameroon for his valuable suggestions concerning the programme, with special reference to mobile clinics, their role in health service delivery and their cost-benefit ratio, particularly in serving nomadic populations. Special mention should be made of a small programme on clinical technology that was being developed with the help of various nongovernmental organizations, whereby surgical, medical, paediatric, obstetric, gynaecological and anaesthetic procedures could be carried out by a qualified physician at first level referral hospitals. It was hoped that those procedures, after field testing, could be widely introduced in developing countries and could form a useful link between primary health care and the higher echelons of medical care in a country setting.

In reply to the comment by the delegate of Uruguay on the decrease in funding for programme 12.1, he was glad to be able to state that extrabudgetary resources had made up for the reduction and in fact the only position that had been dropped was that of a laboratory specialist in Argentina, and the programmes in all countries were being carried out satisfactorily.

The delegate of Belgium had suggested that clinical laboratories should be more closely involved in environmental monitoring. The Health Laboratory Technology Unit was cooperating closely with the Division of Environmental Health in the preparation of a portable laboratory kit for monitoring drinking-water quality; that kit was being evaluated in China. In cooperation with the Regional Office for the Western Pacific, a national training course on environmental microbiology was being organized for the autumn of 1985 in Viet Nam. The delegate of Belgium had also commented on laboratory techniques for developed countries. The above-mentioned Unit had for some time been engaged in a programme for the assessment of the technical criteria indicated by the Belgian delegation had been developed and evaluated successfully. Its production was currently being organized in China and it was hoped that it would be made available to other countries at a reasonable price. Local production in other developing countries having the necessary infrastructure would be promoted and 60 units should be available at the end of the year for the final field trial of the industrial model. Similar studies of various other instruments were under way. Taking advantage of monoclonal antibody technology, emphasis had been placed on the development of reagents for simple instantaneous tests which could bring many microbiological tests to the peripheral level, thus considerably increasing the potential for diagnostic support of laboratories situated at health centres. WHO collaborating centres were being encouraged to expand their research in that area. There was clearly a need for better laboratory support for epidemiological surveillance, and the Health Laboratory Technology Unit was working in cooperation with the Division of Epidemiological Surveillance and Health Situation and Trend Assessment and the Division of Communicable Diseases on a joint programme document for the establishment of a plan of action under which WHO would cooperate with governments in strengthening local capabilities for disease surveillance and control. The development of a network of peripheral laboratories provided a good opportunity for providing countrywide information on the prevalence of many transmissible diseases.

As regards radiological technology, the Yemen Arab Republic had been the first country where basic radiological system (BRS) field testing had been started in 1980. That experience had been useful in improving the design of the BRS machine and training package.

In connection with programme 12.4 (Traditional medicine), the very important point raised by the delegate of Cameroon had been the subject of a recent consultation on approaches for policy development on traditional practitioners, including traditional birth attendants, held in New Delhi; the report of that consultation would be issued in the near future. It was hoped that similar consultations could be organized on a regional and country basis. It had been noticed that in many countries physicians themselves took undue advantage of WHO's appeal for the use of traditional medicine and tried to profit by the situation, as the delegate of Nigeria had pointed out. In reply to the delegates of Cameroon and China, who had stressed the need for exchange of information on traditional medicine, he said that an international newsletter on the subject was being produced by the WHO collaborating centre at the University of Illinois (United States of America) for publication three times a year and to be supplied free of charge to researchers and other interested parties in developing countries through the WHO programme coordinators' offices and regional offices. The newsletter would report not only on WHO activities, but also on important developments at the country and regional levels as communicated to WHO.

The utilization of traditional medicine in national primary health care, mentioned by the delegates of Togo and Lesotho, would be the subject of the technical discussions at the Regional Committee for the Western Pacific, in September 1985. In addition, as the delegate of China had said, an interregional seminar on the subject was to be held in China in October 1985 with a view to giving those responsible for health policy at the national level an opportunity of studying the use of Chinese traditional medicine in primary health care and discussing the possibility of adopting comparable approaches in the provision of health services in their own countries. Some delegates had requested more support for the programme. Regular budgetary resources were unfortunately limited, and that situation would continue for some years. WHO would, however, make every effort to mobilize more funds from extrabudgetary sources for that important programme.
With respect to programme 12.5 (Rehabilitation), the delegate of Canada had referred to a very important aspect of the programme. In response to resolution 37/53(1982) of the thirty-seventh session of the United Nations General Assembly, which requested WHO to revise the standard definitions of impairment, disability and handicap, and following the discussions at the Thirty-seventh World Health Assembly and the seventy-fifth session of the Executive Board, the revision of those definitions had been under continued active consideration: consultations had been held with a number of bodies, including Disabled People's International, and the whole question of the definition and classification of impairment, disability and handicap would be discussed at a meeting scheduled for the end of June 1985, to which a Canadian participant had been invited. The subject of disablement - concepts, definition and data - had been further discussed at a meeting held recently at the Fogarty International Center, at which two eminent speakers had expressed their appreciation of WHO's efforts to classify impairment, disability and handicap. With regard to the Canadian delegate's specific question concerning the involvement of disabled people's organizations in the process of revising the provisional terminology, WHO had had a number of contacts with individuals and organizations of disabled people and the matter had been raised at several meetings and in informal contacts. The Organization had been represented at the World Congress of Rehabilitation International held in Lisbon in 1984 and would participate in a similar conference to be held by Disabled People's International later in 1985.

In conclusion, the Government of Botswana had been very helpful to WHO in receiving a large number of visitors wishing to study its community-based rehabilitation programme. The following week, it would be hosting a special course on community-based rehabilitation management, which was a cooperative effort between the International Committee of the Red Cross and WHO. The training of middle-level rehabilitation assistants was very important and WHO hoped soon to assist Member States in establishing training schools for that group, supported by funds from nongovernmental organizations.

CONSIDERATION OF DRAFT RESOLUTIONS

Prevention of hearing impairment and deafness

The CHAIRMAN invited the Committee to consider a draft resolution on the prevention of hearing impairment and deafness presented by the delegations of Bahrain, Belgium, Kuwait and Lebanon.

Dr AL-AWADI (Kuwait) introduced the following draft resolution on behalf of the sponsors:

The Thirty-eight World Health Assembly,

Recognizing that the attainment of health for all requires increased activity for the prevention of hearing impairment, which affects at least 8% of the population in every country, and of deafness, which is estimated to afflict 70 million people in the world;

Recognizing also that in developing countries most of the hearing impairment, which occurs in excessive prevalence in some communities, results from causes that can be prevented at the primary health care level, and that much of the deafness is reversible or remediable;

Able of the international action being taken to limit the misuse of ototoxic agents and to reduce noise-induced occupational deafness;

Aware also of the rapid advance of technology in otolaryngology and audiology and of the development in some countries of mass treatment programmes using techniques appropriate for the control of hearing impairment and deafness;

Welcoming the readiness of the international nongovernmental organizations to coordinate their activities in support of global, regional and national programmes for the prevention of hearing impairment and deafness;

REQUESTS the Director-General, in collaboration with governments and appropriate nongovernmental organizations, to assess the extent, causes and consequences of hearing impairment and deafness in all countries, and to make proposals to the Thirty-ninth World Health Assembly for strengthening measures of prevention and treatment within existing programmes of health and development.

He pointed out that some 8% of the population of every country in the world suffered from deafness or impaired hearing. The majority of cases of deafness or hearing impairment occurred in the developing countries, although impaired hearing was preventable if the proper
health care was provided and many cases of deafness were treatable. The prevention and treatment of deafness and hearing impairment were very important factors of general, social and mental health, and he urged the Committee to approve the draft resolution on that universal problem. Adoption by the Health Assembly of the resolution would result in proposals being made in various countries for better prevention techniques and treatment in the framework of general health development. The draft resolution had been prepared with the assistance of interested nongovernmental organizations, and he would like Sir John Wilson, representative of the International Agency for the Prevention of Blindness, to address the Committee on the subject.

Sir John WILSON (International Agency for the Prevention of Blindness), speaking at the invitation of the Chairman, said that deafness was a readily preventable, though much neglected disablement, affecting an estimated 70 million people in the world.

Surveys in Asia, Africa and Latin America had shown that more than 10% of schoolchildren had a hearing impairment. In the developing countries the overwhelming cause, otitis media, was easily detectable by mothers or primary health care workers, and could be cured by a simple course of antibiotics. Measles, another major cause, could be controlled by immunization. Control of otitis media and deafness at the level of primary health care could halve the incidence of deafness within a single generation in a typical developing community. Meningitis was a cause of sudden total deafness: a tragic consequence of the recent outbreak in West Africa was that many of the people already blind from onchocerciasis were now also deaf from meningitis. Just as the control of trachoma had led to a dramatic reduction in blindness in many countries, so the control of otitis media - which paralleled trachoma in many of its areas of prevalence, and was treatable by much the same strategy - would have a similar impact on deafness and hearing impairment in a very short time.

Another parallel between deafness and the blindness prevention programme was that, with modern simplified techniques, middle ear surgery, like the cataract operation, could now successfully be - and was being - performed in rural mass treatment projects, where the cost of an operation to improve hearing need not exceed 15 dollars. Operations of that kind that he himself had witnessed in Thailand, India and Kenya had provided a convincing illustration of the need for essential surgery at the first referral level.

Three world organizations concerned with the medical and social aspects of deafness enthusiastically supported the draft resolution before the Committee. They were substantial organizations, with groups in more than 100 countries. They had pledged cooperation globally, regionally and nationally and could undoubtedly raise substantial nongovernmental funds once a strategy had been formulated.

In the past few weeks, those organizations, in collaboration with the Government of Thailand, had established a regional training centre for rural ear specialists and auxiliaries. The necessary appropriate technology was already available and was advancing rapidly.

He stressed that the object of the draft resolution was not a new vertical programme, with its attendant financial implications. The proposal did not involve any significant budgetary commitment, yet it could be the beginning of real action in the interests of some of the most isolated and frustrated people in the world.

Dr WESTERHOLM (Sweden) said that hearing impairment was a severe and common handicap and that many children throughout the world lost their hearing unnecessarily for lack of early treatment of meningitis and ear infections. Inadequate occupational safety measures and unawareness of the dangers of noisy working environments also caused hearing impairment which could have been prevented by relatively simple means. Her delegation therefore supported the draft resolution.

Professor LAFONTAINE (Belgium) stressed the fact that there were not only deaf and blind people, but also people who were hard of hearing or had poor eyesight. Special emphasis should be placed on the problem of early diagnosis in children, in order to prevent situations which might lead to what might be mistaken for mental retardation. It would also be useful if the International Federation of Otorhinolaryngological Societies could participate in WHO efforts in that field.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) and Dr AL-JABER (Qatar) supported the draft resolution and asked that their delegations' names should be included among the sponsors.
Dr SAVEL'EV (Union of Soviet Socialist Republics) and Dr OLDFIELD (Gambia) also supported the draft resolution.

The CHAIRMAN noted the consensus in favour of the draft resolution proposed by the delegation of Kuwait on behalf of the sponsors.

The draft resolution was approved.¹

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA38.19.

The meeting rose at 18h00.
1. SECOND REPORT OF COMMITTEE A (Document A38/34)

The CHAIRMAN read out the draft second report of the Committee.

The report was adopted (see document WHA38/1985/REC/2).

2. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1986-1987: Item 22 of the Agenda (Documents PB/86-87 and EB/1985/REC/1, Part II) (continued)

CONSIDERATION OF DRAFT RESOLUTIONS (continued)

Implementation of strategies for health for all by the year 2000

The CHAIRMAN drew the Committee's attention to the draft resolution presented by the delegations of Cuba, the Democratic People's Republic of Korea, India and Yugoslavia. The draft resolution read as follows:

The Thirty-eighth World Health Assembly,
Bearing in mind the serious adverse implications of the continuing global economic crisis for international development, cooperation, national development policies, the achievement of balanced economic and social development, and the availability of international and national resources for health;
Recalling that the Member States of WHO have unanimously adopted a long-term common policy and strategy for achieving the goal of health for all by the year 2000;
Considering that the present critical economic situation is a serious constraint to the achievement of this goal;
Emphasizing the importance and urgency of devising effective measures to overcome this constraint and to ensure the achievement of the goal of health for all by the year 2000;

REQUESTS the Director-General:

(1) to prepare a report on the repercussions of the world economic situation on the national, regional and global efforts undertaken by Member States in order to achieve the goal of health for all by the year 2000, including recommendations on ways and means of achieving that goal, for submission to the Executive Board at its seventy-seventh session and to the Thirty-ninth World Health Assembly;
(2) to transmit his report to the Secretary-General of the United Nations for circulation to all its Member States.

Mr BALAKRISHNAN (India), introducing the draft resolution, said that the continuing global economic crisis could lead to a drying up of resources needed to achieve the common goal of health for all by the year 2000. It was necessary, therefore, to examine the situation carefully and to devise means which would enable that goal to be achieved even in difficult circumstances.

The Director-General would be presenting a detailed report on the implementation of the strategy for health for all by the year 2000 to the Executive Board and the Health Assembly in the following year.
The draft resolution had been endorsed by the ministers of health of non-aligned and other developing countries at their ninth meeting earlier in the month (see document A38/INF.DOC./11).

Dr SAVEL'EV (Union of Soviet Socialist Republics), speaking on behalf of the delegations of the USSR, the German Democratic Republic and Czechoslovakia, proposed two amendments that would provide a more precise description of the current economic crisis without affecting the substance of the draft resolution. The first amendment would be to delete "global" from the first line of preambular paragraph 1 and to insert the following words: "afflicting many countries" after "crisis" in the second line of that paragraph. The second amendment concerned the third preambular paragraph, where he proposed inserting the words "in many countries" after "economic situation".

Dr HOPKINS (United States of America) wished to put on record his reservation as to whether WHO was the appropriate body to prepare such a report and whether it had the necessary resources to do so.

Dr COHEN (Adviser on Health Policy, Director-General's Office) drew the Committee's attention to the fact that the Executive Board would be reviewing an agenda item entitled "Economic strategies in support of the strategies for health for all by the year 2000" at its forthcoming session in January 1986. If the Committee adopted the draft resolution under consideration, the Director-General would be able to provide an additional report to the Executive Board to complement the one that he was already preparing on that subject.

Dr SURONO (Indonesia) supported the draft resolution.

Mrs GARCIA (Cuba) fully supported the preparation by WHO of a report on the repercussions of the current economic situation on the attainment of the goal of health for all by the year 2000.

Mr BALAKRISHNAN (India) said that his delegation was able to accept the proposed amendments, since they did not appear materially to change the substance of the draft resolution. He also welcomed the clarification provided by Dr Cohen.

The draft resolution, as amended, was approved.1

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

The CHAIRMAN drew the Committee's attention to the draft resolution presented by the delegations of Bangladesh, Cuba, Democratic People's Republic of Korea, India and Yugoslavia. The draft resolution read as follows:

The Thirty-eighth World Health Assembly,

Recalling resolutions WHA28.75, WHA28.76, WHA29.48, WHA30.30, WHA30.43, WHA31.41, WHA32.27 and WHA34.36, and the importance of technical and economic cooperation among developing countries (TCDC/ECDC) as a fundamental element of national, regional and global strategies and the need for strengthening the WHO programme to promote TCDC/ECDC and provide support to developing countries for the establishment and implementation of that form of cooperation;

Reaffirming resolutions WHA35.24, WHA37.16 and WHA37.17, especially in view of the concrete activities initiated during 1984 in implementing the medium-term programme (1984-1989) and the initial plan of action (1984-1985) adopted by the Eighth Meeting of Ministers of Health of the Non-Aligned and other Developing Countries and welcomed by the Thirty-seventh World Health Assembly;

Noting with satisfaction from his introduction to the proposed programme budget for the financial period 1986-1987 that the Director-General intends to initiate action to build up critical masses of health-for-all leaders, and considering the need for the preparation of a comprehensive strategy for leadership development through a variety of actions;

1 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA38.20.
Expressing appreciation of the concrete action taken by the developing countries in the implementation of their medium-term programme (1984-1989) and initial plan of action (1984-1985) in support of the goal of health for all by the year 2000, and particularly the initiation of the process of building up critical masses of health-for-all leaders through international and national colloquia on leadership development for health for all and TCDC and other complementary activities;

Recognizing that the international and national colloquia on leadership development for health for all and TCDC organized in Brioni, Yugoslavia, in 1984 and programmed for 1985 and 1986 in Cuba, Thailand, United Republic of Tanzania, and Yugoslavia, are concrete efforts for the building-up of critical masses of health-for-all leaders;

1. WELCOMES and strongly supports the priority given by the Director-General, in his introduction to the proposed programme budget for the financial period 1986-1987, to the objective of building up critical masses of health-for-all leaders;

2. CALLS UPON all Member States, especially developed countries, and international organizations and bilateral, multilateral, nongovernmental and voluntary agencies, to concentrate their technical and financial cooperation on programmes, actions and activities relating to TCDC/ECDC;

3. REQUESTS the Director-General:

(1) to establish and/or strengthen specific focal points for the promotion and support of TCDC/ECDC in the regional offices and headquarters of WHO, in accordance with resolution WHA32.27, and to strengthen the capacity of WHO programme coordinators at the country level, in order to secure the most effective catalytic action and support of WHO at all levels to countries carrying out TCDC programmes and activities to implement strategies for health for all by the year 2000, and in so doing hasten the decentralization process initiated by the Director-General with the WHO programme budget for 1986-1987;

(2) to report to the Executive Board and to the Health Assembly, in even-numbered years, on the progress made in the catalytic and supportive action of WHO for TCDC/ECDC;

4. REQUESTS the Executive Board to give particular importance to the promotion and support of TCDC/ECDC in preparing the Eighth General Programme of Work covering a specific period and when reviewing programme budget proposals.

Mr BALAKRISHNAN (India), introducing the draft resolution, said that he appreciated the efforts made by WHO to stimulate TCDC/ECDC, which was a powerful method of ensuring efficient use of resources. In that connection he referred to paragraph 14 of the introduction to the proposed programme budget for 1986-1987.

The draft resolution sought the support of WHO and its Member States for activities in that field, especially those which had been identified in the medium-term programme and initial plan of action of the non-aligned and other developing countries. It also sought the support of WHO in strengthening the capacity of the Organization in relation to TCDC/ECDC at all levels.

The colloquia and the idea of health-for-all leaders referred to in the fifth preamble paragraph of the draft resolution were well known, and he was confident that the idea in question would be further refined and developed so as to provide maximum support for activities aimed at reaching the goal of health for all. The draft resolution also requested that matters of TCDC/ECDC should be given due consideration in the preparation of the Eighth General Programme of Work of WHO.

The draft resolution had been considered and fully endorsed at the Ninth Meeting of Ministers of Health of Non-Aligned and other Developing Countries.

Dr SAVEL'EV (Union of Soviet Socialist Republics) said that his delegation supported the draft resolution in principle, in view of the importance of the matters that it dealt with. On behalf of the delegations of the USSR, the German Democratic Republic and Czechoslovakia, however, he proposed that operative paragraph 3(1) should be amended to read: "to take necessary measures in order to strengthen the coordinating role of WHO headquarters, regional offices and WHO programme coordinators in assistance to Member States in carrying out TCDC/ECDC, to implement strategies for health for all, taking into consideration the relevant provisions of resolutions WHA38.11, EB75.R7 and WHA32.27".
Mr BALAKRISHNAN (India) said he could accept the part of the proposed amendment dealing with the decentralization process, but the rest went much further and affected the very object of the draft resolution. Consequently, it was of a substantive nature and he requested that the sponsors should be given time to hold consultations in order to arrive at a suitable text.

The CHAIRMAN invited the delegates of India and the USSR to hold consultations on the drafting of a mutually acceptable text. In the meantime, consideration of the draft resolution would be postponed.

(For continuation, see summary record of the twelfth meeting.)

Maintenance of national health budgets at a level compatible with attainment of the objective of health for all by the year 2000

The CHAIRMAN drew the Committee's attention to the draft resolution presented by the delegations of Argentina, Brunei Darussalam, Cameroon, Central African Republic, Comoros, Djibouti, Egypt, Equatorial Guinea, Fiji, Gabon, Guinea, Jamaica, Libyan Arab Jamahiriya, Mauritania, Morocco, Niger, Nigeria, Rwanda, Solomon Islands, Spain, Sudan, Swaziland and Vanuatu. The draft resolution read as follows:

The Thirty-eighth World Health Assembly,
Consious of the enormous differences in levels of health between the developed and the developing countries, which lack the human, material and financial resources needed to cope with their substantial health problems and to build up their national health services;
Bearing in mind the economic crisis affecting the developing countries;
Considering, furthermore, that policies for economic recovery more especially affect the health services and thus bring in their train pernicious consequences for socioeconomic development;
Reaffirming resolutions WHA30.43, WHA34.36 and WHA35.23 on the policy, strategy and plan of action for attaining the objective of health for all by the year 2000;
Recalling resolution WHA33.17, in which the World Health Assembly decided to concentrate the Organization's activities on the support of strategies designed to achieve that objective;

1. URGES Member States to maintain, or even increase as far as possible, the percentage of national budgetary expenditures devoted to health;
2. REQUESTS the Director-General:
   (1) in collaboration with other international organizations and institutions, to support Member States in this action;
   (2) to report to a forthcoming World Health Assembly on the results of the steps taken in application of this resolution.

Dr FIKRI-BENBRAHIM (Morocco), presenting the draft resolution, said that the goal of health for all by the year 2000 was a utopian one for many countries at a time when their health budgets were being reduced, or at least not being increased. The draft resolution therefore called on Member States to maintain national health budgets at a level such that that goal could be attained. It was in line with, or complemented, other draft resolutions that had been, or would be, submitted to Committees A and B; he had in mind especially that just approved, as amended, on the implementation of strategies for health for all by the year 2000.

Professor DAVIES (Israel) said that his delegation agreed with the sentiments expressed in the draft resolution. However, he would welcome clarification of the third preambular paragraph, since policies for economic recovery would affect health services in a positive way and it was difficult to see how such policies could have pernicious consequences for socioeconomic development.
Dr SAVEL'EV (Union of Soviet Socialist Republics) said that his delegation understood the ideas set forth in the draft resolution. However, on behalf of the delegations of the USSR, the German Democratic Republic and Czechoslovakia, he proposed that the third preambular paragraph should be amended by the insertion of the words "practised by some countries" after "economic recovery". That paragraph, as thus amended, would more accurately describe the situation in many countries.

Dr MAFILAMBA (Cameroon) recalled that the importance of maintaining national health budgets had not escaped the Regional Committee for Africa, which, in its session held at Kigali, Rwanda, in 1978, had drawn attention to the necessity of devoting at least 10% of national annual budgets to health. Since the oil crisis began, there had unfortunately been a continuous erosion of that part of the national budget set aside for health in most of the developing countries. At best, even when there was a quantitative increase in the health budget there was a decrease in real percentage terms. With galloping inflation there were fewer and fewer resources to keep up with current and newly arising needs. The draft resolution therefore came at the right moment, for it was necessary to reverse the present trend and to change the views of financial decision-makers, who regarded health as being economically unproductive. The support of the Director-General would be very useful in making the governments of Member States aware of the resolution.

Dr FIKRI-BENBRAHIM (Morocco), replying to the delegate of Israel, said that the answer to his question could be found in the argument propounded by the Moroccan delegation at the Committee's third meeting. Concerning the amendment proposed by the delegate of the USSR, he agreed in principle, but proposed that, in the third preambular paragraph, the words inserted after "policies for economic recovery" should be "practised by many countries" rather than "practised by some countries", and that the words "more especially affect" should be changed to read "may affect".

Dr SAVEL'EV (Union of Soviet Socialist Republics) agreed to the proposal to replace "some" by "many".

The CHAIRMAN asked if there were any objections to the draft resolution, as amended.

The draft resolution, as amended, was approved.²

Maturity before childbearing and promotion of responsible parenthood

The CHAIRMAN drew the Committee's attention to the draft resolution presented by the delegations of Cameroon, Cuba, Gambia, Ghana, Indonesia, Jamaica, Kenya, Lesotho, Morocco, Nigeria, Norway, Seychelles, Sierra Leone, Somalia, Sri Lanka, United Republic of Tanzania and United States of America. The draft resolution read as follows:

The Thirty-eighth World Health Assembly,
Recalling resolutions WHA31.55 and WHA32.42 on the long-term programme on maternal and child health;
Recognizing the disastrous worldwide health, educational, economic and social consequences of pregnancy in adolescents, and in particular the high risks of maternal morbidity and mortality, as well as low birth-weight with consequent infant mortality and physical or mental handicap which may persist throughout life;
Recognizing that these effects are compounded where poverty, illiteracy, adverse environmental conditions or undernutrition prevail, and where for many reasons prenatal care is not available or sought;
Aware that a large and increasing proportion of the populations of many Member States is adolescent and that trained health workers and resources, especially in rural areas, are too limited to ensure the provision of adequate health services for all;
1. URGES all Member States to act immediately:

(1) to promote the delay of childbearing until both prospective parents, and especially the mother, have reached maturity in adulthood;

¹ See p. 38.
² Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA38.21.
2. REQUESTS the Director-General:

(1) to encourage collaborative action-oriented research on both biomedical and culturally relevant social factors contributing to the prevention of pregnancy before the couple are biologically and socially mature, and on the adverse consequences of pregnancy and childbirth in adolescence;

(2) to increase the Organization's collaboration with Member States and their relevant governmental and nongovernmental agencies in providing primary health care with the emphasis on health promotion and preventive care for adolescents, including family life education, antenatal, delivery and postnatal care, and supporting family services, as an urgent step in the implementation of the 1978 Declaration of Alma-Ata.

Dr SULAIMAN (Nigeria), introducing the draft resolution, pointed out that it was not entirely new, since it was directly related to previous resolutions WHA31.55 and WHA32.42 on maternal and child health, including family planning, and indirectly related to resolution WHA29.50 on birth defect surveillance. The unique aspects of the present resolution were, first, its timing, coming as it did at the end of the United Nations Decade for Women and ushering in International Youth Year with its theme of participation, development and peace; and second, the focusing of attention on the particular problem of adolescence, childbearing before maturity and the need to promote responsible parenthood. Adolescent childbearing in itself presented a great health and social challenge, and timely action was required by actively involving youth in the promotion of health for all.

The problem of adolescent childbearing was related essentially to the individual's passage from childhood to adulthood, both biologically and socially, and to the transition from a traditional social pattern to a contemporary one. Adolescence had been identified as a period during which biological, psychological and social maturation took place; that period, as defined by WHO, lay between the ages of 10 and 19 years. The transition during those years was characterized firstly by biological development from the onset of puberty to full sexual and reproductive maturity, secondly by psychological development from the cognitive and emotional patterns of childhood to those of adulthood and thirdly by emergence from the childhood state of total socioeconomic dependence to one of independence. Pregnancy during that transitional period would therefore present a great diversity of problems.

The size of the problem could be appreciated from the demographic trends. Adolescents formed about 25% of the population and constituted what was called the population momentum, i.e., the potential for rapid population growth. In many societies childbearing was expected to begin soon after marriage. Despite legislative attempts to raise the minimum age, marriage of teenage girls was still common in developing countries. In some countries, a large proportion of women had children before they were 20 years old. Births to adolescents also represented an increasing proportion of all births, a fact partly explained by the comparatively large number of young people in the populations of developing countries. Demographers had shown that early childbearing was associated with high total fertility with all its consequences for the health system.

Especially in developing countries, adolescents were particularly affected by the social consequences of demographic changes. Adolescent pregnancy, particularly in the younger age-groups, was associated with greater mortality and morbidity among both mothers and children. The maternal mortality rate was highest among the very young; but, in addition, reduction in maternal mortality in all age-groups was associated with antenatal care and, unfortunately, experience showed that young women were less likely than older ones to receive such care.

The most common problems of adolescent pregnancy were anaemia, retardation of fetal growth, premature birth, difficult labour and other complications arising from labour. Repeated pregnancies during adolescence increased future risks to reproductive health.

The children of adolescent mothers were more likely to be exposed to illness and injuries, and especially to problems of prematurity, low birth weight and birth injuries. Pregnancies in growing girls meant an increase in nutritional requirement for both the fetus and the mother herself. If those requirements were not met, future physical health might be impaired.
To examine only the physical aspects of adolescent pregnancy was to take too narrow an approach; the social and psychological consequences were equally important. In some traditional societies, adolescent pregnancies occurred under the protection of the family and society. In addition to the medical risks, adolescents were emotionally frightened or disturbed by the anticipated serious social disapproval when their condition became known. Pregnancy was in that case kept secret and no antenatal care was sought until too late; or abortion was induced in late gestation, increasing the risk to health. If the adolescent mothers were still at school, their education was likely to come to an abrupt halt, together with the opportunity for further training. If they were employed, they were likely to lose their jobs in the absence of any legal protection. If they were unemployed, they lost the possibility of achieving economic independence, and might become even more impoverished, to the detriment of their own health and that of the baby.

Marriage as a consequence of pregnancy might mean involvement in parental responsibilities for which the young couple was neither prepared nor sufficiently mature. Adolescent parents might also require more support from their own parents, who might be unable or unwilling to provide it.

A teenage couple or mother could not be expected to have reached the necessary level of maturity for rearing a child and providing it with the physical and mental stimulation needed for optimum growth and development. The first, immediate problem was breast-feeding, which was either unsuccessful or was abandoned in favour of artificial feeding, with increased risks of childhood diseases. In unwanted pregnancies, babies might be abandoned or battered, or become victims of infanticide.

In the light of the above considerations he requested the Committee to support the proposed draft resolution.

Dr HAJAR (Yemen) thought that the draft resolution was very important, since it was concerned with family health. Most developing countries permitted premature marriage, and the bride was often 13 to 14 years old, while the husband was 15 or 16. Despite, or rather because of that fact, his delegation supported the draft resolution, especially with regard to the economic and social consequences of "premature" pregnancy, and therefore asked that that expression be inserted in the draft resolution. With regard to operative paragraph 1, he thought that all Member States should be urged both to encourage the formation of completely healthy families and to promote the delay of childbearing. A firm foundation for the family should be created before childbearing was considered.

Dr SURONO (Indonesia) fully supported the draft resolution, especially from the point of view of improving human resources by reducing infant mortality and promoting family planning. Healthy families had to be promoted right from conception. He therefore welcomed the reference to promoting the delay of childbearing until both prospective parents were mature.

Dr KYELEM (Burkina Faso) fully supported the draft resolution and asked that his country be included as one of its co-sponsors.

Dr MAFIAMBA (Cameroon) observed that, although the harmful effects of pregnancy and childbearing before maturity were well known to gynaecologists and obstetricians, the same could not be said of the man in the street. The International Conference on Population, the second of its kind, held in Mexico City the previous year, had drawn the attention of governments precisely to the dangers of premature childbearing. His own country was trying, through legislation, to raise the legal age for marriage for boys as well as girls, but obviously legislation alone was not enough to change habits and customs. Information and education of the population were needed, but that was a long-term undertaking. In view of the need to reduce maternal and perinatal mortality, which was still very high in the developing countries, his delegation invited the Committee to approve the draft resolution.

The CHAIRMAN asked the delegate of Yemen whether his remarks could be considered as support for the resolution rather than as an amendment to it.

Dr HAJAR (Yemen) explained that he had simply asked for the word "premature" to be inserted before the word "pregnancy" in the second preambular paragraph. He also proposed that the order of subparagraphs (1) and (2) of operative paragraph 1 be reversed.

The CHAIRMAN asked the delegate of Nigeria if those amendments were acceptable to him.

Dr SULAIMAN (Nigeria) said that, since the amendments did not change the substance of the draft resolution, they were acceptable.
The CHAIRMAN asked whether there were any objections to the resolution as amended.

The draft resolution, as amended, was approved.1

PROGRAMME POLICY MATTERS: Item 22.2 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II, Chapter II) (continued)

Health science and technology - disease prevention and control (Appropriation Section 4; Documents PB/86-87, pages 200-274; EB75/1985/REC/1, Part II, Chapter II, paragraphs 57-78; and A38/INF.DOC./7)

Disease prevention and control (programme 13)

The CHAIRMAN reminded the Committee that the discussion of programme 13 would be structured in terms of three blocks of programmes. The first would run from immunization (programme 13.1) to diarrhoeal diseases (programme 13.6), the second from acute respiratory infections (programme 13.7) to other communicable disease prevention and control activities (programme 13.13), and the third from blindness (programme 13.14) to other noncommunicable disease preventive and control activities (programme 13.17). Each block would be introduced separately by the representative of the Executive Board, Dr Borgoño.

He invited Dr Borgoño to introduce programmes 13.1 (Immunization); 13.2 (Disease vector control); 13.3 (Malaria); 13.4 (Parasitic diseases); 13.5 (Tropical disease research); 13.6 (Diarrhoeal diseases).

Dr Borgoño (representative of the Executive Board) said that the Expanded Programme on Immunization (EPI) had been in existence for a number of years, was well organized and was developing well. Two or three aspects of that programme were particularly important, the first being its integration into primary health care activities and, within those activities, in the maternal and child health programme. Secondly, there was the pioneering integration of the training of personnel into the Diarrhoeal Diseases Control Programme and other programmes, which in his view constituted a rational way of using both the Organization's and countries' resources for manpower training. A third and extremely important aspect was the evaluation methodology which EPI had been developing and which could be adapted to this specific aspect of other programmes. He believed that progress was being made towards the achievement of the goals set, if not in 1990, relatively soon thereafter; the Region of the Americas had officially announced in Washington on 14 May the target of eradication of poliomyelitis by 1990 in the Region. That would make it possible to accelerate the achievement of the goals of the Programme; and, at the same time, the very important commitments that countries were taking on and the will of governments to fulfill them gave grounds for optimism about the Programme's success. The allocation in the regular budget had been increased; and although it was true that the total extrabudgetary funds appeared to be less, it was difficult to make a final judgement, since those funds often arrived later, and the amount at the end of the biennium was usually higher. He also commended UNICEF's efficient, timely and comprehensive cooperation in the development of that important Programme.

In respect of programme 13.2 (Disease vector control), more research was needed into the bionomics and ecology of vectors, as outlined in paragraph 7 of the programme statement. Paragraph 9 referred to the WHO pesticide evaluation scheme, which was closely connected with the environmental health and workers' health programmes in view of the health risks run by workers using insecticides. Strengthening of training institutions and intersectoral cooperation were very important aspects of the programme, which had close links with those that followed while dealing also with dengue and dengue hemorrhagic fever.

The situation with regard to malaria (programme 13.3) still gave cause for concern; the epidemiological situation in particular was unsatisfactory. Although the latest statistics indicated a decline in the number of cases as compared with the previous year, the number of countries with a higher incidence of malaria had increased, as a result not only of the problems of developing control programmes, but also of the resistance developed by vectors to insecticides and by Plasmodium falciparum to antimalarials. The malaria programme was an important one, and should be integrated into primary health care; the difficulties facing it would have to be overcome if malaria were to be brought under control and eventually eradicated. He wished to single out the need for research to continue and for a sound

1 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA38.22.
epidemiological and health basis for the control programme which should take into account the epidemiological facts to be faced at the moment and in due course in the integration of control into primary health care.

As regards the other parasitic diseases (programme 13.4), the Health Assembly had been informed at a plenary meeting of advances made in the control of onchocerciasis. Encouraging progress had also been made with the new techniques for the control of schistosomiasis. However, the steady increase in the leishmaniasises was giving some considerable cause for concern and those countries affected should be aware of the epidemiological situation. Regarding Chagas' disease in the Region of the Americas, he informed the Committee that certain chemical compounds had been found which, if added to blood, would prevent transmission of the disease as a result of transfusion. Progress had also been made in standardizing serological diagnostic procedures.

Programme 13.5 (Tropical disease research) was mainly dependent on extrabudgetary resources, which were dwindling, and it seemed that the desired level of funds would not be achieved for the biennium 1986-1987, thus continuing the trend of the three previous years. The Executive Board had been informed of the progress made towards a malaria vaccine, but concern had been expressed that adequate funds might not be forthcoming to continue the research, although a vaccine would not, in any case, be available before the year 2000 or even later. The Director-General had told the Executive Board that other WHO resources might have to be found for the programme, if necessary. In connection with programme 13.5 he would also like to mention the work done to strengthen the research capabilities of developing countries, which was one of the ways of helping those countries to continue on their own with applied research into their own health problems.

Programme 13.6 (Diarrhoeal diseases) had encouraged applied research into such areas as etiology, pathology, treatment and control and had strengthened national research institutions, thus enabling them to carry out research aimed at solving their own problems. It had helped to reduce mortality, especially infant mortality, and morbidity, in collaboration with other programmes. He commended the joint efforts of UNICEF and WHO in promoting the use of oral rehydration salts and helping countries to produce them themselves. Budget allocations for the programme had been considerably increased.

Dr FERNANDO (Sri Lanka) said that his country had achieved reasonable progress in immunization in recent years by varying the interval between the second and third dose of DPT vaccine. Third-dose coverage had currently reached over 65%. The introduction of measles vaccination had reduced morbidity and mortality from the disease and its after-effects. The difficulty of maintaining the all-important cold chain in remoter areas of developing countries made it even more imperative to develop heat-stable vaccines. In view of the importance of keeping track of the immunization status of mothers and children, his country had set up a new health information system. The immunization programme had been reviewed in 1981 and the problems which had emerged were being tackled.

The resurgence of malaria in the developing countries raised the question of whether the malaria control programme was being properly handled. The funding of malaria control was always a problem in those countries, and his Government had decided that it could only hope to keep the disease under control, with complete eradication remaining a long-term objective, as part of the primary health care programme. Given that malaria control took up two-thirds of the preventive health care budget in Sri Lanka, it was difficult to see how other diseases could be eradicated and health for all achieved. In fact, malaria had been brought under control twice in the previous ten years but had recurred for various reasons, one of which was that funds from the malaria control programme had been diverted to other high priority areas. Thus one measure that could be taken would be to increase the country's preventive health budget, i.e., increase the share of primary health care at the expense of the curative services. Another possibility was to review and streamline activities within the malaria control programme. Two weeks earlier an interministerial meeting had been held in Sri Lanka at which the role of the ministerial authorities responsible for agriculture, the environment and irrigation in malaria control had been defined, thus making for a clear intersectoral approach. The production of a malaria vaccine was the only way to eradicate the disease once and for all. His country therefore supported all research on the development of a vaccine, especially one which would attack the malaria parasite in its gametocyte stage. The Sri Lankan Minister of Health had reiterated that point at the meeting of Commonwealth Ministers of Health, held in Geneva on 5 May 1985.

Sri Lanka was attempting to improve environmental sanitation in order to reduce diarrhoeal disease, but it was a slow process. Health education programmes were being undertaken in the meantime. Home-made solutions and the new-formula oral rehydration salts containing sodium citrate were now being used in the field and in hospitals, and deaths from
diarrhoeal diseases had declined significantly as a result. Primary health care workers were being trained in the control of such diseases and the use of home-made solutions and oral rehydration salts; it was hoped that such training would be completed by the end of 1985.

Dr Sung Woo LEE (Republic of Korea) endorsed programme 13.3 (Malaria), but pointed out that the epidemiological picture of the disease had deteriorated and that there had been an estimated 90 million clinical malaria cases in the world in 1982, millions of whom must have died. In an era of scientific and technological advances in medicine, such as computerized tomographic scanning, organ transplants and genetic engineering, and with only 15 years left to achieve health for all, his delegation could not but commiserate with those who still fell victim to malaria. Extrabudgetary resources for the programme for 1986-1987 had fallen by US$ 2,566,700 as compared with 1984-1985. It was to be hoped that more resources would be allocated to the malaria control programme in the 1988-1989 budget.

He expressed gratitude to the Regional Director for the Western Pacific for the latter's concern for malaria control, as shown by the increase of US$ 637,600 in the regular regional budget (document PB/86-87, Annex 2, page 375). He also wished to thank WHO, the Government of Malaysia and USAID for their support for the training of malaria workers in Kuala Lumpur. The importance of training for health workers in malaria control could not be overemphasized. His delegation supported the draft resolution on malaria control submitted by the delegations of India and Yugoslavia.

Professor SENAULT (France), speaking on programme 13.2 (Disease vector control), said that coordination must be a great problem for the Organization, since many activities in that area could be carried out under various programmes. Perhaps the Secretariat might prepare a table of the various activities proposed, as had been done for other programmes, in order to clarify which activities related to which programmes and to help to avoid any overlap.

His delegation supported programme 13.3 (Malaria). Since 1984, France had collaborated in the programme by organizing courses and in particular an international four-month training course on malaria control held partly in Africa under the aegis of the Organization for Coordination and Cooperation in the Control of Major Endemic Diseases (OCCGE) and in France with the coordinating assistance of the Centre international pour le développement social et la santé communautaire (CIDESCO). His delegation hoped that the WHO programme would work closely with programme 13.5 (Tropical disease research), especially in the areas of research and training, in order to avoid duplication at a time of budgetary constraints. His country supported the tropical disease research programme and had made voluntary contributions to it. There had been encouraging results, especially in recent years, but the imbalance between the extrabudgetary resources for 1986-1987 (some US$ 64 million) and the regular budget contribution (about US$ 2.5 million) gave cause for concern; no doubt the Director-General would achieve a suitable balance. It was important to coordinate the disease vector control, malaria and parasitic diseases programmes in view of the above-mentioned budgetary problems.

Programme 13.6 (Diarrhoeal diseases) was particularly important since the effects of such diseases in association with malnutrition were particularly serious for vulnerable groups, such as children. His delegation welcomed the collaboration between WHO and UNICEF in that area.

Dr MELBYE (Norway) said that programme 13.5 (Tropical disease research) played a leading role in international research in that field; promising results had been achieved in the areas of vector control, diagnosis, treatment and immunology. However, the level of voluntary contributions, on which the programme depended, had fallen short of the approved budget, as the representative of the Executive Board had already pointed out. Just at the stage when the considerable economic and scientific investment might be expected to produce results, support for the programme was dwindling. The Norwegian Government would do its best to continue its financial support for the programme, especially since diseases which were at the present time predominantly tropical, such as leprosy and tuberculosis, had until the beginning of the twentieth century been prevalent in Norway also. He appealed to other delegations to try to obtain more voluntary funds to keep up the fight against such diseases.

Dr BOONYOEN (Thailand) expressed his delegation's concern over the problem of opisthorchiasis, which affected approximately 3 million people living in north-eastern Thailand. Unfortunately, due to the high cost of the specific drug available, Thailand could only afford to provide treatment on a limited scale. It hoped to receive WHO support in order to increase its control of the disease.

1 For text, see p. 157.
Although effective control technologies were not at present readily available for massive application covering the millions of people at risk, it was hoped that research into all aspects of infestation and control through primary health care might yield promising results within the near future.

Dr ABDULLATIF (Democratic Yemen) said that, apart from programmes 13.5 (Tropical disease research), 13.12 (Smallpox eradication surveillance), 13.15 (Cancer) and 13.16 (Cardiovascular diseases), his delegation considered that the programmes listed under disease prevention and control (programme 13) should not be interpreted as vertical programmes, but should be integrated. His delegation would like information as to how that could be done and, if possible, when it could be done.

Ways of achieving such integration should be built into the programmes and extended to other related programmes. For instance, programmes 13.1 (Immunization), 13.6 (Diarrhoeal diseases) and 13.7 (Acute respiratory infections) should be coordinated and all or part of those three integrated with programme 9.1 (Maternal and child health, including family planning).

Once such integration had been established, it must be monitored, and here the programme on organization of health systems based on primary health care could be involved. He realized that it would not be an easy task, but felt that that would be the only effective way of achieving the objectives established.

Dr LEPOO (Finland), referring to programme 13.1 (Immunization), said that his delegation regarded the Expanded Programme on Immunization (EPI) as a top priority since it formed one of the corner-stones of any comprehensive primary health care programme. To reach the goal set for the six targeted diseases by 1990 was a test of the capability of health system infrastructures and managerial skills in Member States' primary health care programmes.

He reiterated his Government's firm commitment to continue to support the programme through voluntary funds, the provision of vaccines and cold-chain equipment, training courses and any other means considered appropriate by WHO.

Attention was drawn, in paragraph 5 of the programme statement, to the scanty information available on immunization coverage. The low figures reported were somewhat discouraging and the factors underlying the situation, listed in paragraphs 6 and 7, raised serious concern about the attainability of the goals for the six target diseases by 1990. His delegation would appreciate a comment from the Organization about how it assessed the present situation and the prospects for attaining the goals.

As an example of the need for constant alertness to the threat of new problems arising in connection with old diseases, he cited his country's recent experience with regard to poliomyelitis. Finland had started its vaccination campaign with a killed vaccine in the late 1950s and the last paralytic case had occurred in 1963. Immunization coverage had been good. In the late 1970s serological surveillance had shown that the antibody titres against poliovirus type 3 were weaker than for types 1 and 2, but that had not been considered serious since there was no poliovirus exposure in the country and the antibody levels in the population were considered satisfactory. Yet, suddenly, in late 1984, an outbreak involving several cases of poliomyelitis had occurred, which turned out to be caused by a new, slightly modified variant of type 3. Eight cases had been confirmed.

To prevent an epidemic, a nationwide vaccination campaign targeted at the entire population had been carried out with a live attenuated vaccine in February 1985 and a population coverage of about 90% had been achieved. No verified complications had resulted from that operation and the situation seemed to be fully under control. It was intended to revert to the use of killed polio vaccine for the routine immunization programme with a new concentrated vaccine requiring fewer injections and giving better immunity against type 3 virus.

The Finnish Government expressed its deepest gratitude to WHO and to the Centers for Disease Control in Atlanta, USA, which had helped the Finnish authorities during that incident. Their assistance had been a model of international collaboration.

Dr REILLY (Papua New Guinea) said that, while all the programmes under disease prevention and control (programme 13) were important, his country was particularly concerned with malaria (programme 13.3), which threatened whole populations in tropical countries. An antimalaria vaccine appeared to be the only real solution and he hoped that a safe and effective one would be produced as soon as possible. His delegation therefore strongly supported the draft resolution submitted by the delegations of India and Yugoslavia on malaria control and proposed that, in the penultimate line of operative paragraph 3, greater emphasis be placed on the development of vaccines by changing the word "including" to "especially".1

1 For text, see p. 157.
His delegation shared the concern expressed by the delegation of Norway concerning the funding of tropical disease research. It would be disheartening if extrabudgetary funds which it had been thought would be available were not to materialize. Every effort should be made to acquire those funds and, if they were not forthcoming, the Director-General should be requested to allocate funds from other sources.

Professor DAVIES (Israel) said that his delegation fully supported all the programmes under programme 13 (Disease prevention and control) and congratulated the Organization on the enormous activity which was planned within the constraints of a limited budget.

He stressed the need for strengthening institutions and for training at all levels. His delegation was therefore pleased to see that aspect emphasized in the programme on disease vector control and believed that it should form a major part of all programmes.

A major problem in the control and monitoring of many of the diseases under discussion was a lack of information on their incidence and prevalence. He therefore echoed the comments of other delegates on the subject of malaria and agreed that emphasis must be placed on the development of a vaccine. He therefore endorsed programme 13.5 (Tropical disease research). It was paradoxical that, while apparently insoluble technological problems in the development of new diagnostic tools were being overcome, and new diagnostic methods and vaccines were likely soon to be produced, it was going to be a more difficult task to test the efficacy of the new vaccines in the field because of lack of epidemiological information from the endemic areas. For that reason, he stressed the need for basic epidemiological education for all those working at community level in primary health care and urged that, in connection with the various programmes, teaching materials be prepared for basic education in epidemiology in order to train field workers to measure and monitor the efficacy of the new tools which the research programmes were providing.

Dr. HOPKINS (United States of America) stressed the importance of all the programmes under disease prevention and control (programme 13), since supporting Member States in their efforts to prevent and control disease was the underlying purpose of the programmes on health system infrastructure and health promotion and care.

His delegation felt that the Director-General's emphasis on specific targets as measures of WHO's accomplishments was most appropriate. It therefore wished to applaud the increase in quantifiable targets in that section of the budget. It noted, however, that there was still a wide variety of types of targets cited for different programmes, e.g., the proportion of countries which had expressed an intention to initiate control measures, the proportion of countries establishing a given programme, the proportion of population reached by specific services, and the expected reductions in morbidity and mortality. In general, his delegation preferred targets related to morbidity and mortality rates, although it recognized that they were not always appropriate and feasible.

His delegation strongly endorsed the programmes under consideration. The descriptions of the activities of the Diarrhoeal Diseases Control Programme, the Expanded Programme on Immunization (EPI), and the tropical disease research programme were especially outstanding in the evidence they gave of progress and in format. The emphasis on the control of diarrhoeal diseases, malaria, diseases preventable by immunization and acute respiratory infections was commendable, as was also the increased attention given to integrated activities against diarrhoeal diseases, malaria and acute respiratory infections especially, each of which depended heavily on early recognition and prompt treatment for the prevention of a fatal outcome.

The United States delegation was concerned to note the significant decline in estimated extrabudgetary funds for EPI as compared with the previous budget, and would like to hear the Organization's views on the expected consequences of that decline.

His delegation specifically endorsed the increase in the budget for malaria control in the African Region and the increased emphasis on taking advantage of new opportunities for the control of schistosomiasis, dracunculiasis, and African trypanosomiasis. As a newly designated WHO collaborating centre for research and training on, and control of dracunculiasis, the Centers for Disease Control looked forward to collaborating with WHO and the Member States concerned in developing better estimates of the prevalence of that disease.

The United States Government had recently increased its support for international health assistance for disease prevention and control in developing countries. The budget for health and related activities of the United States Agency for International Development (USAID) had been increased from US$ 146 million in 1984 to US$ 231 million in 1985. Those additional funds were being focused on significant increases in assistance to programmes for oral rehydration therapy, expanded childhood immunization services, control of blindness due to vitamin A deficiency, and vaccine research and development. Various United States medical research institutions had supported or undertaken extensive research on the development of a
vaccine against malaria. With the co-sponsorship of WHO, UNICEF, UNDP and the World Bank, USAID would help to support the second International Conference on Oral Rehydration Therapy, which it was planned to hold in Washington, DC, in December 1985.

Professor COLOMBINI (Italy) expressed his satisfaction with the importance attached to the Expanded Programme on Immunization in the proposed programme budget. In connection with that programme, the initiative of the Regional Office for Europe, which had brought together in Czechoslovakia representatives of many health authorities, had been highly appreciated, as it had not only led to an exchange of views but had also strengthened the determination to put preventive measures into effect.

Vaccination against measles was particularly important: systematic plans were being implemented in Europe to secure as large a coverage of children as possible. Plans for immunization against measles had also been discussed and approved at the Informal Meeting of Ministers of Health of Member States of the European Communities, held in Venice at the beginning of May.

The Italian delegation had frequently drawn the attention of the Health Assembly and of the Regional Committee for Europe to the seriousness of the problems arising from the resurgence of malaria in nearly all tropical and subtropical regions, including some countries in the Eastern Mediterranean area, and from the progressive growth of resistance of the vectors to pesticides and of the parasites to antimalarials. The control measures so far adopted were becoming less effective and other means of control must be sought through greater efforts in both fundamental and applied research. Italy, which, like other Mediterranean countries, had suffered from malaria for centuries and had eradicated it after great efforts, could only view with concern the deterioration in the epidemiological situation with regard to malaria in the world and would actively participate in any activities aimed at reversing present trends. During the last three years it had organized international courses for training in the field of malaria in cooperation with WHO and the Government of Turkey and hoped to continue such courses and to organize international antimalaria coordination meetings, all of which demonstrated its desire to participate in the fight against the disease. His delegation therefore fully supported the draft resolution submitted by the delegations of India and Yugoslavia.

Professor MULLER (Netherlands) said that rapid scientific advances made it possible continually to improve technologies for disease prevention and control which could be used locally in developing countries. On the whole, WHO was doing excellently in stimulating, coordinating and supporting relevant scientific work, on the one hand, and promoting the application of the new tools thus developed, on the other.

All disease prevention and control programmes rightly aimed at incorporating disease control activities into primary health care. However, newly developed tools would first have to be tested for their effectiveness, efficiency and applicability in the field. Serious efforts were being made, particularly by the tropical disease research programme, to strengthen the badly needed field research capabilities to do that, but much remained to be done. It should be realized that the promising fruits of laboratory research might be wasted if they were not applied to disease control. Moreover, the aim of placing maximum responsibility at grass-roots level with the community should be weighed against the critical vulnerability of some control measures and the monitoring of their effect.

The Expanded Programme on Immunization (EPI) had set an ambitious target, particularly in respect of diseases other than poliomyelitis and neonatal tetanus. On the other hand, the attainment of that target would be a prerequisite for setting morbidity and mortality reduction targets for the first half of the next decade. Even more ambitious was the target of making immunizations available to all children of the world by 1990, unless a very wide definition of "making available" was adopted. In that respect, the situation analysis did not quite match the targets set by the Programme. For example, in 1984, only 30% of infants in the developing world were estimated to have received a third dose of DPT vaccine and the drop-out rate between the first and third dose was estimated to be 40%. In addition, national surveillance systems were inadequate in most countries.

The proposed programme activities for 1986-1987 were of obvious relevance. They contained, however, no reference to alternative strategies to increase immunization coverage - such as immunization days and "commando" operations - to UNICEF's GOBI approach, or to the Consultative Group to Protect the World's Children, which was a global

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1 For text, see p. 157.
2 Four low-cost techniques for child survival: growth monitoring, oral rehydration, breast-feeding, immunization.
immunization initiative. Should immunization be used as the leading edge for primary health care, or was the establishment of primary health care a prerequisite for successful immunization programmes? The shift of funds from intercountry to country activities was to be commended.

Similar questions could be asked in relation to the diarrhoeal diseases programme, where targets were equally ambitious in relation to the situation analysis. However, the programmes appeared to be effective and the close cooperation between EPI and the Diarrhoeal Diseases Control Programme in training and evaluation was commendable.

There was cause for concern in that it had been deemed necessary to emphasize the need to include material on diarrhoeal disease control programmes in the curricula of medical and nursing schools. In many developing countries, village health workers knew more about oral rehydration therapy than did paediatricians.

EPI depended for more than 30% of its funds, and the diarrhoeal diseases programme for more than 80%, on extrabudgetary sources; it was to be hoped that they would continue to flow.

The effectiveness and prestige of the Special Programme for Research and Training in Tropical Diseases in stimulating, coordinating and supporting worldwide biomedical research efforts were beyond doubt. The rate of development of new preventive, diagnostic and therapeutic tools for tropical disease control was impressive. Obviously the Special Programme contributed only a small proportion of the total global effort and the current fast developments made coordination even more important than before; the programme appeared to fulfil that role quite well. The Special Programme's budget provided for US$ 66.7 million for the coming biennium, of which US$ 64 million were extrabudgetary funds. In the present state of external funding, that amount was unlikely to be reached, with the inevitable need to cut back on planned activities. The Netherlands delegation shared the views expressed by the delegate of Norway in that respect.

The meeting rose at 11h15.
TWELFTH MEETING

Thursday, 16 May 1985, at 14h30

Chairman: Dr D. G. MAKUTO (Zimbabwe)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1986-1987: Item 22 of the Agenda
(Documents PB/86-87 and EB75/1985/REC/1, Part II) (continued)

CONSIDERATION OF DRAFT RESOLUTIONS (continued from the eleventh meeting)

Technical cooperation among developing countries in support of the goal of health for all
(continued from the eleventh meeting, page 131)

At the request of the CHAIRMAN, Dr RAY (Secretary) read out the amendments submitted by
the delegations of Czechoslovakia, the German Democratic Republic and the Union of Soviet
Socialist Republics to the draft resolution. They consisted in the deletion, in the second
line of operative paragraph 3(1), of the words "and headquarters", and in the sixth to eighth
lines of all after "by the year 2000".

The CHAIRMAN invited the Committee to approve the draft resolution as amended.

The draft resolution, as amended, was approved.¹

PROGRAMME POLICY MATTERS: Item 22.2 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1,
Part II, Chapter II) (continued)

Health science and technology - disease prevention and control (Appropriation Section 4;
Documents PB/86-87, pages 200-274; EB75/1985/REC/1, Part II, Chapter II, paragraphs 57-78;
and A38/INF.DOC./7) (continued)

Disease prevention and control (programme 13) (continued)

The CHAIRMAN invited the Committee to continue its examination of programmes 13.1
(Immunization); 13.2 (Disease vector control); 13.3 (Malaria); 13.4 (Parasitic diseases);
13.5 (Tropical disease research); and 13.6 (Diarrhoeal diseases).

Dr BISHT (India) said his delegation supported programme 13 in general.

In regard to programme 13.1 (Immunization), although India was able to manufacture most
of the vaccines required for its immunization programme, the country had not yet reached
self-sufficiency in poliomyelitis and measles vaccines. There was still a need for WHO
support and know-how.

His delegation was submitting a draft resolution on malaria (programme 13.2), which
still represented a major problem.² He commended in that connection the excellent work of
the vector control unit at Pondicherry and the high grade technical support received from
WHO. Successful results in both north and south India had shown that malaria could in fact
be controlled by careful attention to ecological factors and vector control. Experience had
also demonstrated the need for maximum epidemiological support, not only in the immediate
present but also in the future when more effective tools became available for diagnosis,
treatment and prevention. Great emphasis had therefore been placed on epidemiological
studies in medical school curricula and at the postgraduate level.

In regard to parasitic diseases (programme 13.4), everyone was aware of the vicious
circle of malnutrition, parasitism, and the diseases current in the vulnerable groups; an

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as
resolution WHA38.23.
² For text, see p. 157.
even greater effort would have to be made in that field. Steps were being taken in India, for example, to eradicate dracunculiasis by the year 1990, and the experience gained would be readily shared with others in order to eradicate the guinea-worm from the whole world.

There was an opportunity for research in regard to drugs for the treatment of leprosy, cholera, etc., with the aim of increasing the rapidity of the action of the drug so as to reduce the time within which infection could be transmitted. It was a field of research with great cost-benefit potential, and one in which pharmaceutical companies might be interested.

Dr THEIN DAN (Burma), while fully supporting the extremely comprehensive and feasible programme on disease prevention and control, drew attention to the fact that the programme had been allocated only 15.41% of the effective working budget for 1986-1987. That figure appeared hardly adequate against the background of widespread communicable diseases, especially in the developing countries. He hoped that the possibility of obtaining additional extrabudgetary resources for that programme would be energetically explored.

Dr MGENI (United Republic of Tanzania) said that human disease was only a manifestation of the failure of the human body to withstand external aggression of a physical, chemical, biological or psychosocial nature, and any action to counter disease had to be directed against the causative factors. In his country particular attention had been paid to malaria and diarrhoeal diseases in view of the consistently high morbidity and mortality rates, but effective control of those diseases necessitated the deployment of enormous resources, and external support was urgently needed. His delegation fully endorsed the programme on disease prevention and control, and supported the draft resolution on malaria control.

He expressed particular gratitude to the countries and agencies which had contributed to the Arab Gulf Programme for United Nations Development Organizations (AGFUND), which had provided substantial support for malaria control in his country. Some success had already been achieved with malaria control in Zanzibar (with the support of USAID) by means of residual spraying in the rural areas, ultra-low-volume spraying in urban and periurban areas, and chemotherapy. A preliminary assessment of the effectiveness of those measures had indicated a reduction in malaria prevalence in one district from 57% to 19% within a short period.

Dr QUBEIN (Jordan) emphasized the importance of an integrated approach to immunization, diarrhoeal disease control and maternal and child health. Regarding malaria, it was necessary to bear in mind the environmental risk inherent in the use of insecticides; intensive research on malaria vaccines was a more positive approach than extensive spraying with insecticides. Means should also be found of attacking the malaria vector at a vulnerable stage in its life cycle. Malaria had been eradicated from Jordan in 1976, and it was general policy to take blood samples at the frontier from visitors coming from infected areas and treat those suffering from malaria. In regard to diarrhoeal diseases, particular emphasis had been placed on oral rehydration, which was available to the whole population as standard treatment.

Dr FIKRI-BENBRAHIM (Morocco) said that his delegation supported programmes 13.1 to 13.6 and the budgetary allocations made to them. It welcomed in particular the substantial increase in the budgetary and extrabudgetary resources allocated to diarrhoeal disease control (programme 13.6). Considerable progress had been made in this field in many countries, but the research component appeared to be lagging behind owing to the difficulties experienced by developing countries in planning their operational research; WHO support in that respect would be very valuable. The Organization should also strengthen the coordination of research on diarrhoeal diseases, both at the regional and global levels.

His delegation supported the draft resolution on malaria control.

Dr OWER (United Kingdom of Great Britain and Northern Ireland), fully supporting programme 13.1 (Immunization), said that the situation analysis identified two longstanding factors - which he hoped would now be removed - contributing to the delay in achieving targets: the absence of public and perhaps political commitment to immunization programmes and lack of management skills to implement a programme successfully. Education of health workers was another vital element in immunization, since many workers tended to be too ready to postpone the immunization of children because of minor illness, thus losing their only opportunity to immunize children against target diseases, many of which were still major killers. It was also necessary to guard against the false sense of security induced by

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1 For text, see p. 157.
successful immunization programmes, and ensure that immunization rates were maintained. Since conditions varied from country to country, he was in favour of the shift of funds from intercountry activities to direct support of activities in individual countries.

Malaria (programme 13,3) was once again posing a major worldwide threat, perhaps because of previous success in reducing the incidence of the disease, which had caused a false sense of security and a relaxation of control measures. It was clear that the malaria programme would become increasingly important. A number of centres in the United Kingdom were undertaking or collaborating in research to develop malaria vaccines and hopefully that approach might provide a solution in the future.

Tropical disease research (programme 13,5) was a most important aspect of the Organization’s work, and he regretted the reduction in the extrabudgetary funds available. The United Kingdom had recently notified WHO that its contribution to the Special Programme for Research and Training in Tropical Diseases for 1985 would be £224 000.

Dr KLIVAROVA (Czechoslovakia) said that programme 13 was the most important part of the programme budget. It was essential to lay the scientific foundation on which the etiology, pathogenesis and early detection of diseases were based. That applied also to the prevention, epidemiology, diagnosis and treatment of diseases. Studies were required on radiological and new rapid laboratory diagnostic procedures. It was rightly stressed in the programme statement that disease control must be carried out within the primary health care services; she would add that those services were in fact an integral part of the national health system.

Regarding immunization (programme 13.1), it was right to insist that children’s diseases should be the primary target of immunization efforts. The immunization system in Czechoslovakia, which was already well established and implemented by primary health care workers, had led to the eradication of poliomyelitis, diphtheria, measles, whooping cough and tuberculosis in children, and vaccination against parotitis and rubella had been introduced. It was some indication of the favourable results achieved that Czechoslovakia had been chosen as the host country for the Second Conference on Immunization Policies in Europe held in December 1984. In addition to the four areas listed in paragraph 20 of the programme statement, concerning evaluation, it might be worth adding a study of the status of immunity in particular population groups which had undergone immunization.

Regarding the parasitic and tropical diseases (programmes 13.4 and 13.5), her delegation was pleased to see that great advances had been made in research, largely funded from extrabudgetary resources. Czechoslovakia had recently agreed to participate as a donor to the Special Programme for Research and Training in Tropical Diseases. It had already sent a number of health workers and specialists to the developing countries under technical cooperation projects and an Institute of Tropical Medicine and Health was shortly to be established in Prague.

Dr BOB’OYONO (Cameroon), referring to immunization (programme 13.1), shared the Organization’s concern at the low immunization rate in the world as a whole, and more particularly in the developing countries. Against the background of economic austerity, priority should be given to preventive measures, especially vaccination; more intensive research on vaccine development and the improvement of existing vaccines was clearly needed. Malaria was a case in point: chloroquine resistance was becoming a progressively more serious problem.

There were two main reasons for the slow improvement in the immunization status of developing countries: the multiple doses required to achieve immunization and the thermolability of vaccines. Recent information concerning a whooping cough vaccine effective in two, instead of three, doses showed that a step had been taken in the right direction, but real progress would only be made when a single-dose vaccine was made available. The immediate introduction of a two-dose vaccine might in any case merely cause confusion. Thermolability was a further complication in connection with the establishment of cold chains and the problem of vaccine viability. Solution of the thermolability problem would permit an expansion of immunization programmes and thus a wider immunization coverage. Cameroon looked forward to the day when oral vaccines would become available, thus simplifying administration and helping the battle against diarrhoeal diseases, in particular cholera, where some of the pathogens had acquired multiple resistance to antibiotics.

Dr BROTO WASISTO (Indonesia), commending programme 13.1 (Immunization) and the part of the Board’s report dealing with that subject, said that the Expanded Programme on Immunization had been operating in his country for 10 years. Despite some progress in reducing the incidence of diseases preventable by immunization, further strengthening of the programme was needed, as the results had so far fallen short of expectations. He asked whether WHO was sponsoring research on the development of room-temperature stable vaccines.
He noted that there was a decrease of 7% in real terms in the total proposed budget for the programme, and requested clarification on the substantial reduction in the allocation for intercountry and regional activities in the African Region and the significant increase for country activities in the South-East Asia Region.

Expressing his agreement with the situation analysis concerning malaria (programme 13.3), he requested clarification on the slight decrease in the country allocation for the South-East Asia Region and significant increase in that for the Western Pacific Region. His delegation would favour a real increase in the total allocations for the programme rather than an overall decrease as proposed. He further requested information on progress in developing an antimalarial vaccine and the prospects for the year 2000.

His delegation welcomed the progress made in the programmes for the control of diarrhoeal diseases (programme 13.6). The significant increase in the proposed budget reflected a stronger commitment to a high priority programme. It was also gratified to note the increased assistance being provided by other international agencies. While fully supporting the proposed programme activities, he felt that, in view of the estimate in paragraph 8 of the programme statement regarding access to and coverage by oral rehydration therapy, the proposed target of 50% access by 1989 was over-ambitious.

Dr CORNAZ (Switzerland), referring to the general programme statement for programme 13 (page 200), regretted that, while the situation concerning communicable and noncommunicable diseases had been well analysed and due reference had been made to primary health care, not enough emphasis had been laid on the social, economic and cultural factors determining the state of health of populations. Her delegation would have liked it to be stated more clearly that a vertical approach to disease control was not sufficient in itself, and that disease control measures should be part of overall development efforts. Rather too much emphasis had been laid on technological aspects in paragraphs 5 and 6 of the programme statement. While technology was important, social, economic and cultural factors could prevent its dissemination and proper use, while in other cases social conditions could be a genuine asset in disease prevention and control. For that reason WHO should pay due attention to such factors, which were to be seen in terms of their interrelationship with technological factors. Epidemiology, which could often provide the knowledge needed for effective disease control, should also be accorded due attention.

Regarding programme 13.1 (Immunization), more attention should perhaps be given in applied research and evaluation to the reasons why some programmes had not achieved the expected results; there, too, in addition to technical, administrative or manpower problems, social, economic and cultural considerations might be contributory factors. Her delegation had noted with some surprise that the only reference to UNICEF in programme 13.1 was in connection with training materials, whereas UNICEF accorded high priority to immunization activities in its programme, and there should be optimal coordination between the programmes of the two organizations, both in planning and in carrying out immunization campaigns.

Regarding tropical disease research (programme 13.5), Switzerland - which co-financed the programme - would be presenting its comments when the Joint Coordinating Board met in June 1985. She would, however, like to stress the particular importance it attached to the study of socioeconomic factors and epidemiological research, side by side with medical and biological research.

Switzerland also contributed to the programme of WHO - as well as to those of other organizations - on diarrhoeal diseases (programme 13.6), and therefore participated in meetings of interested parties, which provided an opportunity for more detailed discussion of the subject. At present she would merely stress that it was important for WHO to contribute actively to the control of such diseases, which were a particularly serious problem in the Third World, and to coordinate its efforts - both in research and in support to national programmes - with those of other organizations and institutions. Priority should be given to simple, low-cost and effective means of prevention and control that were accessible to populations, especially the most disadvantaged and high-risk groups; that included the preparation by families of solutions of oral rehydration salts or rice water. The development of such means also presupposed clinical and, especially, epidemiological and community research into the various forms of diarrhoeal disease, including shigellosis, which had not been sufficiently studied to date. Efforts should then be focused on disseminating such methods among communities and health workers.

Dr WALSH (Ireland) expressed his delegation's appreciation of programme 13. Referring to programme 13.1 (Immunization), he said that poliomyelitis and diphtheria had been eradicated in his country and that, given sufficient stimulus and commitment, the same result should be possible the world over. In autumn 1985 an intensive campaign of immunization against measles would also be conducted in Ireland. Drawing attention to the bad media image
of pertussis vaccine in some countries, based on alleged serious neurological reactions following pertussis vaccination, he said that WHO could be of great assistance in emphasizing support for pertussis vaccination and creating a more positive public attitude. The level of "uptake" of pertussis vaccination was falling in Ireland, and pertussis was re-emerging as an epidemic disease. He wondered whether other countries were experiencing the same phenomenon.

He would also be interested to know WHO's policy regarding rubella vaccine and its use in the control of congenital rubella syndrome.

Dr BRITO GOMES (Cape Verde) expressed support for programme 13.3 (Malaria). There had been no recorded case of malaria in his country since 1982, but Anopheles gambiae was still present and vector control needed to be strengthened - particularly in view of the contacts with countries where malaria was still endemic. Close collaboration among countries and between them and WHO was essential to prevent the reintroduction of malaria in such cases. He supported the draft resolution relating to malaria control which would be considered subsequently by the Committee.1

Similarly, while there were no cases of yellow fever in his country, epidemiological surveillance and vector control, with the assistance of WHO and other organizations, continued to be necessary.

In regard to diarrhoeal diseases (programme 13.6), inadequate drinking-water supply and related problems made diarrhoeal disease control a major public health priority in his country, where 25% of deaths of children under the age of one year were the result of diarrhoeal diseases.

Turning to programme 13.1 (Immunization), he said that in his country there was a high incidence of communicable and parasitic diseases, accounting for 52% of consultations. Although there was a marked decline in diseases preventable by immunization, it was necessary to extend immunization coverage by improving the cold chain and ensuring a regular supply of vaccines.

Dr SAVINYH (Union of Soviet Socialist Republics), referring to programme 13.1 (Immunization), said that the Expanded Programme on Immunization was one of the most highly developed mechanisms for reducing morbidity and mortality resulting from the most common communicable diseases. The programme was, however, facing some difficulties, both in the developing and in the developed countries. In the former there was inadequate immunization coverage of the population because the supply of vaccines was inadequate and the use of qualified staff was not always rational. On the other hand, as the coverage increased the lack of vaccines would be felt more acutely; there was therefore a need, as his delegation had repeatedly stressed, to encourage countries, groups of countries and regions to develop their own vaccines. In that connection, it would be expedient to consider the question of the use by countries of specialists trained with WHO's assistance - an aspect that was relevant to other programmes also.

The Second Conference on Immunization Policies in Europe, held in Czechoslovakia at the end of 1984, had put a number of interesting and topical questions to the developed countries, the answers to which could be extremely useful to all countries in achieving the targets of the programme.

A point of great interest was cooperation between the Expanded Programme and the new programme for vaccine development, which would help to overcome some of the difficulties faced by the immunization programme. Soviet specialists and institutions were conducting research, in collaboration with WHO, on specific measures for disease prevention. Those efforts were of a long-term character, and his country was prepared to extend them to include other programmes - such as the Diarrhoeal Diseases Control Programme, particularly with regard to training. Certain approaches adopted under the Expanded Programme could well benefit other WHO communicable disease control programmes.

He expressed approval of the basic approach under malaria (programme 13.3) - further emphasis on the integration of antimalaria activities into national primary health care services, and the development of research on new effective means of malaria control. Applied research should be coordinated and directed more towards areas of research that were of global significance - in particular, improving methods of controlling tropical malaria and its drug-resistant forms. Attention should also be given to the operational aspects of control activities; demonstration projects might be set up in countries, particularly for programmes to prevent the development of drug-resistant malaria. His delegation would submit in writing two amendments to the draft resolution on malaria control.2

1 For text, see p. 157.
2 See p. 158.
The programme on diarrhoeal diseases (programme 13.6) had used with success the experience acquired in other programmes, and its two basic components - the operational and research aspects - were well balanced. His delegation had no objection to the proposed budget for the programme, but stressed the need to pay increased attention to applied research on improved simplified methods for rapid diagnosis, specific prophylaxis (effective oral vaccines, accessible to all), and oral rehydration therapy, including oral rehydration salts and improved solutions. In view of the complexity of the subject, it should be considered by the global Advisory Committee on Medical Research. The service component of the programme seemed effective, and good progress had undoubtedly been made. It was necessary, however, to extend the use of oral rehydration therapy, both in curative centres and at the community level, through seminars and training projects for health workers; some aspects of the programme might possibly be included in medical faculty curricula.

Dr ROSDAHL (Denmark) supported programme 13.1 (Immunization), particularly the Expanded Programme on Immunization. With the growing international awareness of the importance of immunization programmes, there was hope that the programme targets would be met by the end of the century. The importance of the Expanded Programme as an entry point into the primary health care system had often been emphasized, but that presupposed that its activities be integrated into primary health care structures, and progress towards that end was laudable. Development required patience on the part of all involved; often it might be quicker, and therefore tempting, to create separate vertical delivery systems, parallel to the national health structures. That temptation should be resisted, and his delegation therefore welcomed the Director-General's emphasis in his opening address to the Health Assembly on the need to build up permanent comprehensive health delivery systems for lasting impact. The Expanded Programme was to be commended for the technical support it provided to national immunization programmes.

Control of diarrhoeal diseases (programme 13.6) was an important part of national health strategies, but should be fully integrated with primary preventive measures, including the provision of safe water. Coordination and cooperation with other relevant WHO programmes should be increased at both the global and country levels. Further encouragement should be given to the organization of training workshops for diarrhoeal disease control jointly with the Expanded Programme on Immunization.

His delegation supported the comments of the delegate of Norway concerning tropical disease research (programme 13.5). Given the paucity of funds allocated to tropical disease research in the world, WHO's work was crucial in that field. His country had supported the programme from the outset and shared the concern expressed by the representative of the Executive Board that the programme had not attracted sufficient external support to cover the proposed budget; that was particularly regrettable in view of the fact that important scientific breakthroughs seemed possible in the near future. He urged Member States and other potential donors to contribute or increase their contributions to that important programme, and welcomed the increased allocations under WHO's regular budget.

Dr RAHMAN (Bangladesh) expressed support for programme 13.6 (Diarrhoeal diseases), and appreciation of the priority given to it. His Government, recognizing the importance of the problem of diarrhoeal diseases, had established an International Centre for Diarrhoeal Disease Research in Dhaka in 1978. The centre was actively collaborating with WHO in the field of diarrhoeal disease research, the application and dissemination of research findings, and training. It had carried out significant research, including that leading to the establishment of the now widely accepted oral rehydration solution as an effective tool in combating dehydration due to diarrhoea and subsequent mortality.

He regretted that in paragraph 10 of the programme statement, referring to biomedical research, no mention was made of the institutes or organizations operating in that field without any financial assistance from WHO. He expressed gratitude to WHO, UNDP, UNICEF, the World Bank, USAID, AFGFUND and the governments of Australia, Japan, Saudi Arabia, Switzerland, the United Kingdom and others for their support to the centre, which served as a training centre for nationals of his country and from other countries of the Region.

Dr REZAI (Islamic Republic of Iran), commenting on programme 13.1 (Immunization), drew attention to the fact that the estimated immunization coverage in children up to the age of 12 months had not yet reached one-third of the target. According to a report presented to the Expanded Programme's global Advisory Group in November 1984, in developing countries the coverage for the third dose of DPT vaccine was 28%, for poliomyelitis 26%, for BCG 30%, and for measles only 15%, with only 11% of pregnant women receiving two doses of tetanus toxoid. In the list of 25 countries with the highest population there were at least five whose coverage for DPT, poliomyelitis and measles remained below 10%. It was accordingly hard to
see how the goal for 1990 could be achieved on a worldwide scale; to raise the level of immunization coverage during that short period to an extent that would significantly reduce mortality and morbidity due to the target diseases would be an extremely difficult task. There would appear to be no ready answer to the problem. Consideration should be given to whether a partial answer would emerge as a result of the acceleration of immunization activities by means of national immunization days. Possibly, governments might consider making immunization against the six target diseases compulsory and a prerequisite for issuing permanent birth certificates for children. He would welcome the views of the Organization.

With regard to programme 13.2 (Disease vector control), he emphasized the problems facing antimalarial operations. The vector had developed resistance to most groups of insecticides. Furthermore, the effective insecticides available were costly; for example, in his own country indoor insecticide spraying alone cost approximately US$ 40 million each year as part of the malaria eradication programme. There was also the possibility of environmental pollution and poisoning of domestic animals to be taken into account, as well as the reluctance shown by the rural population towards frequent spraying of their premises. WHO had recommended an integrated approach towards vector control, which implied the application of chemical, biological and environmental management measures. In that regard, he asked what measures were proposed to ensure the appropriate training of personnel.

Dr BATCHVAROVA (Bulgaria), commenting on programme 13.3 (Malaria), said that malaria was still a major public health problem in many developing countries, particularly in Africa. In view of the lack of specific preventive methods and adequate control measures, it was necessary to concentrate efforts on reservoirs of infection and on vectors. If satisfactory results were to be achieved, countries should have a national programme for intersectoral cooperation aimed at carrying out comprehensive measures to fight vectors, as well as having the necessary infrastructure within the health services, including primary health care, in order to help promote activities in malaria control. If the targets mentioned in paragraph 2(2) of the programme statement were to be realized, WHO should concentrate its effort in the coming years on giving the programme a number of basic thrusts: preparation of a malaria vaccine; development of new drugs with long-term effects; cooperation with Member countries in the promotion of scientifically-based malaria control programmes in accordance with local conditions; manpower training; and the exchange of experience.

Her country was one of those which had succeeded in eradicating the disease, and it was therefore prepared to assist other countries in implementing that important programme in a number of ways. Bulgarian specialists could be included in scientific programmes developed by WHO, and Bulgaria could also help in the continuing training of health manpower, both on an individual basis and through international courses organized in the country.

Dr UNSAL (Turkey) said that his delegation fully supported programme 13.

With regard to programme 13.3 (Malaria), he recalled that Turkey had been one of the countries where malaria had been eradicated in the late 1960s. However, a new epidemic of Plasmodium vivax malaria had since broken out, some 115 000 cases having been recorded in 1977. Considerable multisectoral and international efforts had been made since 1978 to control the disease, and he expressed warm appreciation to WHO and other international organizations, as well as other countries, for their assistance.

There were a number of reasons for the resurgence of malaria in Turkey. There had been a loss of vigilance in the national health services due to the long duration of a strictly vertical eradication campaign conducted by manpower engaged solely for that purpose. There had since been a shortage of experienced manpower following eradication and before the integration of antimalarial activities into the national health services; that had diminished the chances of early diagnosis and rapid treatment which constituted the corner-stone of all control programmes. Furthermore, undiagnosed malaria cases had been imported into the country, and certain climatic, social and economic conditions had favoured malaria transmission in some areas, leading to cases of unrecognized local transmission. Regional agricultural and industrial development had encouraged the migration of persons from affected regions, and the problem had been compounded by the movement of parasite carriers among seasonal agricultural workers. In addition, resistance had developed in vectors to almost all types of insecticides used for agricultural purposes in southern Turkey, and expansion of irrigation and drainage schemes had facilitated the breeding of mosquitoes. Further factors included man-mosquito contact facilitated by rapid urbanization in unhealthy conditions.

The integration of antimalarial activities into national health services was vital in order to maintain vigilance against a disease that had been controlled by vertical programmes in the past. However, there was also clearly a need for more knowledge and experience, and
personnel working in the administration and management of primary health care needed to be trained in the control of specific diseases such as malaria.

Turkey had considerable experience in that field, and was ready to share it with countries suffering from a shortage of manpower. He referred to three international training courses held in 1981, 1982, and 1983, organized by WHO in collaboration with the Governments of Italy and Turkey. Training had been provided in Italy, in Rome and Palermo, for some 60 participants from different countries on the integration of malaria activities into primary health care; practical training in such aspects as residual indoor spraying, larviciding, space spraying and engineering methods for vector control, and surveillance activities, had been given in Adana, Turkey. His Government was grateful to WHO and to the Italian Government for their cooperation.

Since malaria was an international problem, all countries, whether affected by malaria or not, should join in helping each other. His Government was eager to share its experience for the benefit of others, and would welcome international training courses in Turkey organized and supported by WHO.

In that spirit, and recognizing the crucial importance of a multisectoral approach, including governmental and nongovernmental organizations, as well as the community, his delegation fully supported the draft resolution on malaria.1

Dr OKWARE (Uganda) considered, in connection with programme 13.3 (Malaria), that the target of reducing annual malaria morbidity to less than 1% by 1989 appeared somewhat over-ambitious. Indeed, it would appear that problems hampering progress, such as inflation and shortage of antimalarials, as well as inadequate development of logistic support, would continue, especially in developing countries, many of which had a tropical environment which favoured the vector and the plasmodium. Another obstacle lay in the constantly changing epidemiological and ecological characteristics of the vector and parasites.

Experience so far had shown that success in eradication of malaria had not been long lasting. He would, however, concur with the view that the morbidity due to malaria could only be dramatically changed through a far-reaching technological breakthrough, such as the development of a vaccine.

His delegation was somewhat apprehensive at the anticipated real decrease of 6.84% shown in the regular budget in respect of 1986-1987, and would welcome reassurance that that reduction would not in any way hamper progress towards the development of primary health care and new techniques against malaria. It also wondered whether there was any possibility of reallocating funds for that important purpose. In other respects, his delegation would fully commend the Director-General's efforts in preparing the programme budget.

He also supported the draft resolution on malaria control, submitted by the delegations of India and Yugoslavia, and requested that his delegation should be listed among the co-sponsors.1

With regard to programme 13.4 (Parasitic diseases), he noted that paragraph 17 of the programme statement included a list of six countries in which the public health rating of onchocerciasis would be assessed. Onchocerciasis was at present a real problem in Uganda, and a definite plan of action was being prepared in that respect. He accordingly requested that Uganda should be added to that list so as to enable it to strengthen and complement the national efforts undertaken towards long-term control of onchocerciasis in the country.

Dr KERE (Solomon Islands) expressed his delegation's appreciation of the important activities being undertaken under programmes 13.1 to 13.6. The Solomon Islands, like other developing countries, still had infectious diseases, particularly malaria, as their most important public health problem.

It should be realized that many of those diseases could be, and had in fact been seen to be, controlled by cheaper means through some appropriate primary health care approaches. Some effective tools for disease prevention and control did exist, the problem being that the available measures simply did not fully reach the target population or provide adequate coverage in all communities to bring about effective results. It was imperative to develop an efficient delivery system whereby the problem could be solved. For instance, a good poliomyelitis vaccine was available, but the disease still occurred since the entire target population was not reached. The Solomon Islands, like other Member States, was looking forward to the day when an effective malaria vaccine would be available. Nevertheless, it

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1 For text, see p. 157.
was important now to establish an efficient operating system in the delivery of immunization so that the much-needed vaccine would actually reach the target population when it did become available. He therefore fully supported operational research in that field. Thanks to the support of WHO and other organizations, the Solomon Islands had for some years past been free of the most important diseases preventable by immunization, and the Expanded Programme on Immunization had already become an integral part of national health care delivery.

His Government fully supported programme 13.3 (Malaria), and was itself laying enormous emphasis on malaria control. Malaria incidence in the country had reached an extremely high peak of 350 per 1000 population in 1983, and approaches to malaria control were consequently being reconsidered. Action based on appropriate primary health care approaches had been taken, which required considerable reorientation and reeducation of health workers and of the community; technical and social adjustments were called for as well as organizational and administrative adjustments. After lengthy preparations in the form of planning and village health education and consultations, closely supervised mass drug campaigns had been instituted in the areas most at risk, during the peak transmission seasons, covering a population of more than 50 000 and using over 1000 village volunteers as drug administrators. In 1984 over 31 000 cases had been prevented, and that had saved the country an estimated amount of at least US$ 90 000. Furthermore, field malaria microscopists had been trained in basic techniques so as to increase the coverage of the basic diagnostic service in the community. That could be regarded as the beginning of primary health care field laboratories. Much still remained to be done, although a start had been made in initiating community source-reduction programmes at the rural level.

His country's experience with drug-resistant malaria, in terms of cost as well as of suffering, was common to other areas of the world. The situation at present was that there were few new effective drugs to fall back upon when one antimalarial failed. His delegation would therefore urge Member States to use the new antimalarials wisely rather than indiscriminately, and thus prolong their effectiveness. The Solomon Islands was in the process of planning a field safety and effectiveness trial of mefloquine/sulfadoxine/pyrimethamine antimalarial drug combination. Furthermore, his country had offered to act as host to a regional vector control workshop and the tenth South-West Pacific malaria meeting, both in 1986.

The Government of the Solomon Islands fully endorsed the proposals under programme 13 and was prepared to cooperate in its implementation. His delegation also fully supported the draft resolution submitted by the delegations of India and Yugoslavia, of which it wished to be a co-sponsor.1

Dr QUAMINA (Trinidad and Tobago) said that programme 13 (Communicable disease control) could probably be generally regarded as constituting the most important group of activities carried out by WHO, and the Organization had carried out its role, as outlined in paragraph 6 of the general programme statement (page 200), with initiative and responsibility, and had set an admirable example of scientific evaluation when dealing with new communicable diseases. Her delegation fully endorsed that role.

As regards Programme 13.1 (Immunization), she approved the emphasis on evaluation in the Expanded Programme on Immunization. Her delegation acknowledged the valuable role of the PAHO revolving fund in the procurement and regular supply of quality vaccines, but noted with some concern the reduction of the provision for that programme under "other sources".

Insect vector control programmes were highly labour-intensive and made heavy demands on her country's limited resources, thus indeed presenting a challenge for effective management (programme 13.2, paragraph 3). Reference had been made to the primary health care approach to insect vector control, and she would welcome further information in that regard. In view of the reported recrudescence of malaria and other insect-borne diseases, she would like to know, in particular, whether there had been any evaluations of those approaches as applied in insect vector control programmes and whether eradication of those vectors had been achieved anywhere by the application of primary health care strategies alone, or had that led to "health-for-all mosquitos"? A fall in breeding indices of more than 50% still fell far short of the target. She considered that, as eradication had been achieved by some Member States in the past, there was a case for re-examining some of the older methodologies, in the light of more recent knowledge and developments of course, with a view to the reintroduction of any of their components that could be identified as having been vital to their success. In particular, it would be interesting to hear what progress had been made by Sri Lanka as a result of applying the intersectoral approach at a high administrative level to vector

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1 For text, see p. 157.
control. She agreed that there was a need for more professionally trained personnel to direct, monitor and evaluate vector control programmes, and fully supported those aspects of the programme.

Her delegation supported the draft resolution on malaria control, submitted by the delegations of India and Yugoslavia.¹

Dr REGMI (Nepal) agreed that diarrhoeal diseases remained a leading cause of child mortality in most developing countries (programme 13.6, paragraph 3). Oral rehydration solution and other treatments, although life-savers, never reached the roots of the problem which lay in poor environmental conditions and in unsafe water, bad sanitation and malnutrition. He would make a plea for help in effecting some measure of a determined attack on the roots of the problem, so that in future proper attention could be given to other pressing problems, such as acute respiratory infections (programme 13.7), which represented another important cause of morbidity and mortality among children in developing countries. Valuable research had been done, and he hoped that the results would be made available as soon as possible to serve as guidelines for management of those infections.

Malaria (programme 13.3), which had been on the verge of disappearing during the 1960s, had reappeared with new vigour, and problems were being encountered as a result of resistance of the Plasmodium to antimalarials combined with mosquito resistance to insecticides. Moreover, the purchase of insecticides was complicated by financial constraints. Malaria should be combated with timely measures, as it could have serious repercussions on the overall development of a country, and WHO should promote the development of vaccines, as well as mobilize assistance from bilateral and multilateral agencies.

Dr HENDERSON (Director, Expanded Programme on Immunization) said that the Expanded Programme was making good progress, owing to the hard work done in the national programmes and the support provided by UNICEF, bilateral development agencies and private and voluntary organizations. Several delegations had noted the difficulty of meeting the goals for morbidity and mortality reduction and coverage by 1990, given the current coverage estimates of some 30% for the third dose of DPT. The question of whether those goals could be met and should be retained deserved full debate, and he hoped that such an opportunity would be made available at the next Assembly. For now, he would only say that he believed that the goals were eminently feasible, but that meeting them would require further programme acceleration and further development of innovative programme approaches and strategies. The delegates of the Netherlands and the Islamic Republic of Iran had mentioned some of those strategies, such as the "commando" operations which had been used in Burkina Faso, the national immunization days used by a number of countries and immunization laws relating to birth certificates or entry into schools; but in that respect great caution had to be exercised because of the degree to which highly spectacular efforts ran the risk of prejudicing the building up of a long-term infrastructure - a point raised by the delegate of Denmark.

The delegate of the Netherlands had asked why those strategies had not been included in the programme budget. It should be noted that the Expanded Programme was evolving rapidly and that when the text had been prepared a year previously very few of the strategies had appeared to be really viable; that opinion was beginning to change in the light of the experience of the past few months. The Expanded Programme was likely to fail to meet its goals in a few countries, but those should represent less than 5% of the total infant population of the developing world.

Mention had been made of the ambitious nature of the Programme's targets, even those proposed for achievement prior to the 1990 goal: they were indeed ambitious, but they could be met. Accurate measurement of morbidity and mortality caused by the target diseases would not be possible in all countries by 1986, but reasonable estimates could probably be made for the diseases that were being used as the main indices of the Programme's impact, namely, poliomyelitis, measles and neonatal tetanus. Much work had been accomplished in the past few months in the development of sentinel surveillance systems, which would be greatly relied upon to indicate trends during the next few years, while the routine reporting systems were being strengthened. Regional disease reduction targets for at least some of the target diseases had already been set in the Region of the Americas and the European and South-East Asia Regions, and the Eastern Mediterranean Region was likely to adopt such targets at a meeting scheduled for July 1985.

Some delegates had expressed concern about the level of extrabudgetary funding in forthcoming years. That indeed remained a matter of uncertainty, and the Expanded Programme lived in a day-to-day situation, not daring to spend all the funds at present committed until

¹ For text, see p. 157.
additional funds were committed for future years, though he had gathered, from the informal statements of individual delegations, that support would continue. The Expanded Programme in fact needed relatively little extrabudgetary funding in comparison with other WHO programmes, but that small amount was critical to enable it to act as a catalyst in supporting national efforts.

Reference had been made to UNICEF initiatives and its drive for child survival and development, and it had been pointed out that very little attention was paid to UNICEF's work in the programme budget. He could assure the Committee that UNICEF was one of WHO's closest partners in the Expanded Programme's activities and that UNICEF efforts over the past two years had been quite extraordinarily effective in providing support at the national level. Indeed, that was one of the fields in which the partnership between the two Organizations was most productive, and it would certainly be strengthened further in the years to come.

The delegate of Indonesia had asked whether any research was being conducted on the heat stability of vaccines. In fact, little research was done in the Expanded Programme, although that specific area might be given further attention as the WHO programme on vaccine development, which was primarily devoted to research, acquired further experience and funding. The role of the Expanded Programme was to stimulate manufacturers to improve vaccine stability standards: four or five years previously, a standard for measles vaccine had been introduced and had led to continuous improvement by manufacturers in the stability of their product, so that many who had not met the standard before were now exceeding it. It might soon be time to review measles vaccine stability standards and to consider raising them further. The Expanded Programme did not engage in any basic research, because it was convinced that the search for better tools should not in any way compromise the objective of putting the existing tools to use as quickly as possible.

The delegate of Indonesia had further commented on the 7% real decrease in the programme budget. It should be noted, however, that country support had been largely increased, and that the decrease occurred at the intercountry and the interregional and global levels. The largest decrease - some US$ 1 million for the African Region - resulted from a redistribution of intercountry funds in that Region: one-third had been transferred from intercountry to country programmes within the Expanded Programme, while two-thirds had been transferred away from that Programme to other communicable disease prevention and control activities (programme 13.13) in the African Region, where it would serve to fund the increased emphasis being placed on response to epidemics - of cerebrospinal meningitis or plague for instance. It was therefore reflected under programme 13.13 in Annex 2 ("Regional activities", page 317). The funds reprogrammed in the African Region were not necessarily lost to the Expanded Programme and could be recovered if the need arose. The reason for the shift was that more national programme allocations were provided for the Expanded Programme and the extrabudgetary funds flowing into the Region had increased: accordingly, the redistribution posed no threat to the efficacy and acceleration of the programme.

The delegate of Ireland had asked whether WHO would lay more emphasis on immunization against pertussis. Under the Expanded Programme attempts were made to provide materials and general background support when individual countries ran into difficulties in that respect, but it should be borne in mind that WHO was neither more nor less effective than governments in mobilizing the media in support of campaigns, and he could not foresee any increased stress on such programmes in the near future. Nor had he any knowledge of declines in the levels of pertussis immunization in countries other than Ireland; in fact, after the regrettable sharp fall that had occurred 10 years previously, he believed those levels were being maintained or were increasing in most countries.

With regard to vaccination against rubella, the European Region had set the goal of eliminating congenital rubella by the year 2000, but the situation in the developing countries was far less clear-cut. If rubella vaccination was included in the Expanded Programme as a childhood immunization and the coverage was not very high, considerable damage could be done because girls not covered by vaccination could then reach childbearing age without being exposed to natural infection. The Programme therefore exercised caution in the matter and would confine itself to advising interested developing countries on optimal policies, although there was little doubt that rubella vaccination should be a component of the programme in industrialized countries.

Dr GRATZ (Director, Division of Vector Biology and Control) said that activities under disease vector control (programme 13.2) were carried out in close coordination with those under malaria (programme 13.3), parasitic diseases (programme 13.4), including the Onchocerciasis Control Programme (OCP), and tropical disease research (programme 13.5) - indeed with all programmes under the Division of Communicable Diseases. Disease vector control (programme 13.2) was a research and development programme providing technical support and new methods and materials for the control of the vectors of disease to those other programmes.
A number of delegates had expressed concern about the problem of insect resistance to insecticides and some had referred to the effect of insecticides on the environment. Pesticides were likely to remain as the mainstay of most vector control programmes in the foreseeable future, but the disease vector control programme was trying to develop and encourage the use of alternative methods of vector control, including environmental and biological methods, the latter in collaboration with the Special Programme for Research and Training in Tropical Diseases. Two biological agents, *Bacillus thuringiensis* serotype H-14 and *B. sphaericus*, were at an advanced level of development, and the first-named bacillus was being used in the Onchocerciasis Control Programme (OCP) to control blackflies resistant to temephos (the first insecticide used in the OCP) and was also very widely employed in the United States for pest mosquito control. It should be pointed out that most of the environmental pollution and many of the effects of pesticides on non-target organisms throughout the world were caused by agricultural pesticides rather than by those used in public health programmes, which were generally very selective in the manner of their application.

The importance of training in vector control had been stressed by a number of delegations. With the collaboration of the Special Programme for Research and Training in Tropical Diseases and with national and bilateral funding, the disease vector control programme had established seven master of science courses in medical entomology and vector control. With the support of DANIDA, two or three short courses in vector control were held every year. In response to a comment by the delegate of the Islamic Republic of Iran, a way of making vector control more effective and cheaper in the future would be to have a nucleus of well-trained professionals and groups to advise primary health care staff in the periphery and in villages on how to carry out vector control more selectively and effectively.

In reply to the delegate of Trinidad and Tobago, there was no reason why the application of vector control in primary health care programmes should not be effective, but there were, of course, a number of problems in that connection. The disease vector control programme was working closely with the regional offices in their country programmes and an Expert Committee was to meet in 1986 to consider how to introduce vector control into primary health care. That was another high priority in the vector biology and control programme.

Dr NAJERA-MORRONDO (Director, Malaria Action Programme) expressed his appreciation of the statements made in support of the programme on malaria (programme 13.3) and of the awareness and concern shown about the precarious epidemiological situation. A number of delegates had rightly stated that the solution must be sought by incorporating malaria control as an integral part in primary health care. Past experience had shown that such integration could not be achieved by mere administrative action and that a thorough review of the strategy was essential. Malaria control had to be based on a solid epidemiological approach in order to select and evaluate appropriate technologies adapted to local conditions and to optimize the support and supervision of their application. In that epidemiological approach, full importance must be attached to the appreciation of sociocultural and economic factors affecting the intensity and extent of the problem and influencing the effect of control efforts. Moreover, in taking that approach and in the validation of new technology in the field, the highest possible competence of health services in the epidemiology and control of malaria was essential. Appropriate training and strengthening of institutions and services were fundamentally important, as was maintenance of the competence of services through exchange of experience and information and intercountry and/or international cooperation. Special thanks were due to the Governments of Belgium, France, Italy and Turkey for their support of international training courses. Many other governments had offered their training facilities to other countries; special mention should be made of the interregional Secretariat for the Coordination of Malaria Training in Asia and the Pacific, established at Kuala Lumpur, which coordinated such training in those regions.

Progress in the development of malaria vaccines was satisfactory, but it could hardly be expected that vaccines would be available for malaria control in the immediate future, since they would have to undergo clinical and field trials to ascertain their safety, acceptability and efficacy. Those trials currently depended on the availability of competent services in malarious countries, whence the need for training and health infrastructure development. Although vaccines would in the future undoubtedly be very useful tools in malaria control, they might not be a panacea, and the delegate of the Solomon Islands had rightly stressed the need to develop new drugs and to use the available ones wisely. In that connection, guidance had already been provided by the Scientific Group on Chemotherapy of Malaria and in the recently published report of a WHO Scientific Group on Advances in Malaria Chemotherapy.1

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Over the centuries, malaria had proved to be a very adaptable biological complex, well adjusted to the environment and producing a resilient ecological system. Accordingly, ecological research for malaria control should be continued and supported.

It had been suggested that the clinical and field trials of antimalarial vaccines should be internationally coordinated by WHO. To that end, a joint meeting of the Scientific Working Groups on the Immunology of Malaria and Applied Field Research in Malaria of the Special Programme for Research and Training in Tropical Diseases had been held in February 1985 and had developed guidelines for malaria vaccine trials which were to be published in the very near future. Further support was needed for epidemiological and general field research into the development and improved use of malaria control measures.

With regard to the question raised by the delegate of Indonesia concerning the reduction in the country activities for the South-East Asia Region, it would be seen that that decrease of US$ 69 700 was relatively small and was offset by extrabudgetary support from a number of bilateral development agencies. The reduction of US$ 245 900 in the intercountry budget for that Region reflected the advances made in intercountry projects and the reassignment of programme groups, with the result that, for instance, the post of a specialized malaria entomologist had been converted into that of a parasitologist.

Finally, the Regional Director for Africa had informed him that interest in the problem of malaria was not decreasing in that Region but that, on the contrary, as much support as possible was being given to the programme, particularly to the development of integrated approaches to control.

Dr DAVIS (Director, Parasitic Diseases Programme) expressed his gratitude for the interest and stimulating comments of delegates.

In reply to the delegate of France, he said that there was great awareness of the need to avoid duplication in WHO's programmes. As indicated by the previous speaker, there was close technical cooperation among all those concerned. The programmes for parasitic diseases under the regular budget were closely associated with those of the tropical disease research programme. A list of activities for those units funded by the regular budget was given in the medium-term programme for each division or programme.

The delegate of Israel had stressed the importance of teaching and training, particularly in epidemiology. WHO organized regular teaching courses in basic and advanced epidemiology and control of schistosomiasis, intestinal parasitic infections and African trypanosomiasis. All the courses had strong biostatistical, ecological, human behavioural and parasitological elements. By the end of the biennium 1984-1985, courses on schistosomiasis would have been given in Botswana, Burundi, Egypt, Kenya and Sudan. Courses on intestinal parasitic infections would have been given in Brazil, Cuba, India, Lesotho, the Seychelles, the South Pacific Islands and the United Republic of Tanzania. Major courses in African trypanosomiasis would have been completed in Cameroon, Congo and Zimbabwe, with additional national courses in the Central African Republic, Cameroon, Ivory Coast, Mali and Togo. In addition, there was constant in-service training for individuals at the Daloa Centre for African Trypanosomiasis, in the Ivory Coast. Plans for the biennium 1986-1987 were well advanced, with teaching courses in over 12 countries.

The delegate of the United States of America had mentioned advances in the control of schistosomiasis, dracunculiasis and African trypanosomiasis. WHO looked forward to close cooperation with its new collaborating centre for dracunculiasis.

The representative of the Executive Board had drawn attention to the spread of leishmaniasis throughout the world. WHO had recently published a technical report on the leishmaniasis which presented the policies for research and control for the coming five years.¹ The report had been well received by the Executive Board and Member States.

The delegate of Thailand had expressed concern at the high cost of drugs for the control of opisthorchiasis, which had limited his country's control activities. Negotiations were under way with the manufacturer. As they were at a sensitive stage he preferred merely to say that the prospects of achieving an appreciable price reduction over the next few months were good, with about 95% probability of success. A meeting had been held in the Democratic People's Republic of Korea during 1984 for countries in the South-East Asia Region, since the undoubted advances in the methodologies for schistosomiasis control had stimulated interest in similar methodologies for the other snail-borne trematode infections, clonorchiasis, opisthorchiasis and paragonimiasis. Morbidity control through population-based chemotherapy was possible and feasible for all those infections, but it was much less easy to alter human behavioural factors, such as age-old eating habits.

The delegate of India had drawn attention to the vicious circle of parasitism and malnutrition. WHO was organizing a course, to be held in New Delhi later in 1985, with a strong emphasis on that relationship, which would hopefully stimulate local interest. He had also referred to his country's programme for the control of dracunculiasis. That programme was an example to the rest of the world. Indian expertise was now well known and would certainly be used in the future.

The delegate of Uganda had stated that onchocerciasis was a growing problem in his country, WHO was very willing to add Uganda to the list of countries for increased assistance in onchocerciasis research and control.

Dr Lucas (Director, Special Programme for Research and Training in Tropical Diseases) expressed his thanks for the encouraging comments of delegates. He confirmed that rapid scientific progress was being made on all fronts. Several new products, such as mefloquine, Bacillus thuringiensis serotype H-14, and African trypanosomiasis diagnostic tests were already in operational use as a result of support from the tropical disease research programme. Several other products were in the pipeline: field trials were being conducted with the leprosy vaccine; clinical trials were being undertaken with new drugs for the treatment of onchocerciasis; and at least four pharmaceutical companies had offered new antimalarial drugs that were almost ready for evaluation in man.

In answer to the various questions concerning the malaria vaccine, he reported that rapid progress had been made over the past year. Considerable interest was now being shown by the pharmaceutical industry, which should accelerate the development of vaccines still further. Three main types of vaccines were being developed: work on sporozoite, asexual blood stage and sexual stage vaccines was being undertaken in many different parts of the world. There were three main approaches to the production of the antigens: genetic cloning, synthesis of specific polypeptides, and recombinant DNA technology, using the vaccinia virus as the vehicle. Development of the sporozoite vaccine was the most advanced and was likely to be ready for the first cautious clinical trials in the next two years. Even at that stage much more work would be needed. The Director of the Malaria Action Programme had drawn attention to the long, tedious and time-consuming task of evaluating the efficacy and safety of vaccines, especially for use in the developing countries. It might be relatively easy to produce a vaccine suitable for tourists and other short-term visitors, but the evaluation of vaccines for the protection of indigenous populations in endemic areas would be a much more difficult and lengthy process. WHO had a special responsibility in facing that task. The prospects for malaria vaccines were justifiably exciting and, hopefully, vaccines would become powerful additions to the armamentarium for malaria control. There were grounds for optimism but caution should be exercised and efforts to develop other control measures should not be relaxed. Therefore, the tropical disease research programme was continuing its search for new drugs for treatment and prophylaxis and, as he had already mentioned, several new drugs would hopefully be available soon for use in man. Innovative approaches to vector control were also being pursued. One of the agents being investigated, Bacillus sphaericus, seemed promising, and he hoped to report progress on that to the Health Assembly at a later date.

In answer to the delegate of India, he said that the development of long-acting formulations of drugs was an important area of research supported by the tropical disease research programme, and some progress had been made. For example, the Scientific Working Group on Chemotherapy of Malaria had done much work on the subject so that when new drugs for the treatment of malaria became available they could be formulated in such a way that a single dose would provide protection for several weeks or even months. With the new drug being evaluated, in collaboration with industry, for the treatment of onchocerciasis - ivermectin - a single dose produced a sustained fall in the microfilaria count in the skin over several months. That type of drug was most useful. The well-known leprosy drug dapsone was being reformulated, and an injectable form that gave several weeks of sustained blood levels would soon be ready for testing in man.

Reference had been made to training in epidemiology. The Special Programme's Steering Committee on Epidemiology had given a high priority to training. Courses were being conducted, some in collaboration with other programmes, and the development of new training materials was being supported.

The delegate of Switzerland had emphasized the need to take account of social and behavioural factors. Research on those aspects was being supported by the Special Programme's Scientific Working Group on Social and Economic Research.

The representative of the Executive Board and several delegates had referred to the financial constraints on the Special Programme. He thanked the Member States and other agencies that had made generous donations: the results now being achieved were the product of that investment. The funds available to the Special Programme had declined, and that was
reflected in the decline in the number of active projects in 1984. In his opinion, financial resources were the most important factor in determining the rate at which new tools for malaria control could be developed by the Programme. He could not therefore give an assurance that shortage of funds would not affect their development. The tropical disease research programme was currently rejecting research projects and requests for training and institute strengthening which, according to the best scientific advice, would accelerate such development. He felt that it was his responsibility to draw the attention of delegates to the implications of the financial constraints.

Dr Merson (Director, Diarroheal Diseases Control Programme) welcomed the encouraging comments made by delegates.

The delegates of Indonesia, the Netherlands and the United States of America had referred to the targets of programme 13.6 (Diarroheal diseases). Although the targets appeared to be ambitious, progress had been made in a number of country activities and in improving access to oral rehydration therapy using home solutions and ready prepared oral rehydration salts (ORS). For example, the minimum access rate for children aged under 5 years to ORS had increased to 21% globally by 1983. In countries for which most information was available, the minimum access rate was 34%. It was too soon to determine whether targets for use of oral rehydration therapy and mortality reduction would be reached, but they were still considered to be feasible and success would depend on the continuous growth of national diarrhoeal disease control programmes, especially in areas where those diseases were most prevalent.

He assured the delegates of Cape Verde and Nepal that WHO was aware of the urgent need to accelerate efforts to reduce diarrhoea morbidity, and training and evaluation activities in that area were being increased.

A number of delegates, including those from Denmark and Democratic Yemen, had emphasized the importance of integrating diarrhoeal disease control with other key primary health care programmes. He endorsed that approach. WHO was continuing to seek ways in which the activities of the diarrhoeal diseases programme could be coordinated with those of other WHO programmes. For example, collaboration was under way with: the Expanded Programme on Immunization, and programmes 13.7 (Acute respiratory infections), 9.1 (Maternal and child health, including family planning) and 11 (Promotion of environmental health) in the further development and expansion of the integrated approach to the management training of supervisors; with the Expanded Programme on Immunization, under programme 13.1, and programme 13.7 (Acute respiratory infections) in morbidity, mortality and coverage surveys; with the Division of Strengthening of Health Services, the Expanded Programme on Immunization and the Division of Family Health in the development of a useful and effective protocol for joint programme reviews; and with programme 12.2 (Essential drugs and vaccines) for ORS production. WHO was also collaborating extensively with UNICEF in all those areas. Because of the high frequency and mortality of diarrhoeal diseases, the activities of the Diarrhoeal Diseases Control Programme were a key entry point to primary health care in most developing countries. Those national control programmes could only be implemented effectively as part of general health care services.

The delegates of Morocco, Switzerland and the Union of Soviet Socialist Republics had supported the strengthening of applied research activities, now under way in some 50 countries. The regional offices, which had responsibility for managing operational research in the diarrhoeal diseases programme, had taken steps to improve activities, aiming to support projects directly related to issues and problems being faced in national diarrhoeal disease control programmes. One of the best approaches was to identify applied research priorities at the time of evaluation and reviews of national control programmes. At global level a new scientific working group was being set up that would be responsible for supporting research to test the efficacy of specific anti-diarrhoeal interventions. Efforts would also be increased to identify and test more effective oral rehydration solutions, which would significantly decrease diarrhoeal stool volumes, for use in both the home and treatment centres.

In reply to the delegate of Cameroon, he said that new oral vaccines were currently being field tested for cholera, rotavirus, typhoid fever and shigellosis. More research was needed on the prevention of shigellosis, especially that due to Shigella dysenteriae type 1.

WHO was collaborating closely with a number of international and bilateral agencies who were also supporting diarrhoeal disease research. The International Centre for Diarrhoeal Disease Research, in Bangladesh, had made important contributions to the treatment of diarrhoea and WHO looked forward to increased collaboration with the Centre in the future.

The Diarrhoeal Diseases Control Programme was collaborating with the Special Programme for Research and Training in Tropical Diseases in the training of epidemiologists in field research, mentioned by Dr Lucas.
CONSIDERATION OF A DRAFT RESOLUTION

Malaria control

The CHAIRMAN invited the attention of delegates to the following draft resolution on malaria control sponsored by the delegations of India and Yugoslavia, and noted that the delegations of Cuba, Solomon Islands and Uganda wished to be included as co-sponsors:

The Thirty-eighth World Health Assembly,
Recalling resolutions WHA28.87, WHA29.73 and WHA31.45;
Noting that the problems caused by the spread of malaria in many developing countries in tropical and subtropical zones are adversely affecting health and socioeconomic development in these countries;
Recognizing that coordinated efforts are necessary to prevent further deterioration of the situation;
Bearing in mind that control of malaria is essential in the context of the implementation of the Global Strategy for Health for All by the Year 2000;
Realizing that malaria control programmes are extremely complex and that full and active community involvement is essential in order to achieve the desired objectives;
Taking note of the report of the WHO Study Group on Malaria Control as Part of Primary Health Care;1

1. RECOMMENDS that malaria control should be developed as an integral part of national primary health care systems;

2. URGES the Member States concerned:
(1) to undertake an immediate review and appraisal of the malaria situation and of existing control strategies, in terms of their effectiveness, efficiency, and prospects of achieving and maintaining their objectives, as a basis for planning the necessary modifications to maximize their contribution to the objective of health for all;
(2) in compliance with the targets of the Seventh General Programme of Work, to plan antimalaria activities utilizing appropriate technologies in order to prevent the deterioration of the malaria problem in the immediate future and to ensure sustained progress in control;
(3) to mobilize adequate national resources for malaria control;

3. REQUESTS the Director-General to continue his efforts, in coordination with other international agencies, to provide technical support and to assist in the mobilization of adequate resources at national and international levels for malaria control in endemic countries, giving particular attention to the development and strengthening of intercountry technical and operational collaboration, including research for the development of vaccines against malaria.

Dr GEORGIJEVSKI (Yugoslavia), speaking on behalf of the sponsors, said that the resolution had been drafted at the ninth Meeting of Ministers of Health of Non-aligned and other Developing Countries, held in Havana in March 1985, and had been reviewed by the ministers of health of the non-aligned countries at a meeting held in Geneva on 8 May 1985.

Malaria was becoming one of the most serious problems in the developing countries. Although WHO and Member States were making tremendous efforts to control the disease, progress over the last 15 years had been insufficient. Parasite resistance to drugs, vector resistance to insecticides, changes in vector behaviour, with avoidance of insecticide-treated surfaces, and the considerable increase in costs of malaria control operations, were among the difficulties encountered. Increased population mobility and international travel, and lack of flexibility in antimalaria and general health services were preventing the optimum utilization of resources. Efforts were now needed to mobilize all possible resources to improve the situation, with the incorporation of appropriate antimalaria activities in primary health care systems and the development of flexible plans for malaria control, adapted to local conditions. The necessary support and technical cooperation should be encouraged. The draft resolution was therefore most timely.

Dr SURONO (Indonesia) said that, as his country, for instance, consisted of some 13,000 islands spread over a very wide area, research for the development of vaccines should be emphasized rather than merely included in paragraph 3. The word "including", in operative paragraph 3, should be replaced by the word "emphasizing", the last phrase thus being amended to read "emphasizing research for the development of vaccines against malaria".

Dr SAVINYH (Union of Soviet Socialist Republics) proposed that in paragraph 2(3) Member States be requested to mobilize adequate national resources for applied research, as well as for malaria control.

He further proposed that operative paragraph 3 be amended by replacing the words "vaccines against malaria" with the words "effective methods and means for the prevention and control of malaria".

Dr GEORGIEVSKI (Yugoslavia) said that, while the proposed amendments no doubt improved the text, the word "vaccines" had been inserted in operative paragraph 3 during the meeting of ministers of the non-aligned countries at the particular request of the delegation of Sri Lanka. He would therefore be unwilling to see it removed and proposed that the words "including vaccines" be added to the text as amended by the delegates of Indonesia and the Union of Soviet Socialist Republics.

Dr DE SOUZA (Australia) supported the previous speaker. During the discussions, considerable emphasis had been placed on the need for the development of malaria vaccines. It would therefore be inappropriate to delete all reference to them.

Dr REILLY (Papua New Guinea) supported the two previous speakers in their view that specific reference to malaria vaccines in the draft resolution was very important.

In view of the comments made, Dr SAVINYH (Union of Soviet Socialist Republics) proposed that the words "including research for the development of vaccines" be added to his earlier amendment to operative paragraph 3.

Dr REILLY (Papua New Guinea) proposed that the word "including" be replaced by the word "especially", in view of the special importance of malaria vaccines.

Responding to the Chairman's request, Dr RAY (Secretary) said that the final phrase of paragraph 3, as so far amended, would read: ... "research for the development of effective methods and means for the prevention and control of malaria, especially the development of vaccines". It was understood that the draft resolution would be edited to properly reflect the Committee's meaning as it emerged during the discussion.

The draft resolution, as amended, was approved.¹

The meeting rose at 18h05.

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA38.24.
THIRTEENTH MEETING
Friday, 17 May 1985, at 9h00

Chairman: Dr D. G. MAKUTO (Zimbabwe)

1. THIRD REPORT OF COMMITTEE A (Document A38/35)

Mr RUBIO (Peru), Rapporteur, read out the draft third report of the Committee.

The report was adopted (see document WHA38/1985/REC/2).

2. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1986-1987: Item 22 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II) (continued)

PROGRAMME POLICY MATTERS: Item 22.2 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II, Chapter II) (continued)

Health science and technology - disease prevention and control (Appropriation Section 4; Documents PB/86-87, pages 200-274; EB75/1985/REC/1, Part II, Chapter II, paragraphs 57-78; and A38/INF.DOC./7) (continued)

Disease prevention and control (programme 13) (continued)

The CHAIRMAN called on Dr Borgoño, representative of the Executive Board, to introduce the second block of programmes under "major" programme 13, including programmes 13.7 (Acute respiratory infections), 13.8 (Tuberculosis), 13.9 (Leprosy), 13.10 (Zoonoses), 13.11 (Sexually transmitted diseases), 13.12 (Smallpox eradication surveillance), and 13.13 (Other communicable disease prevention and control activities).

Dr BORGOÑO (representative of the Executive Board) said that those programmes were also of considerable importance and had been in progress in the overwhelming majority of countries for some time. Turning first to the programme for the control of acute respiratory infections, he said that programme 13.7 together with the Expanded Programme on Immunization and the Diarrhoeal Diseases Control Programme, formed a trio of great importance in relation to child health and child mortality, especially in developing countries.

As the Committee was aware, acute respiratory infections accounted for 25 to 35% of the child mortality in developing countries; their importance was therefore beyond all doubt. For the past two or three years the feeling had been growing in the Organization, and had been extensively discussed at the Executive Board, that greater impetus should be given to the programme on acute respiratory diseases, which the Board considered to be of fundamental importance. The programme had as its central objective the reduction of mortality, and was founded on two basic strategies: the first was to provide guidance in the handling of cases and their timely and efficient treatment; the second was health education with broad community participation in the programme. The programme had already begun to be implemented in many countries and had been given due priority in primary health care, of which it formed an important element and into which it obviously had to be completely integrated. He believed that the programme would take on exceptional importance during the next biennium.

Referring to programme 13.8 (Tuberculosis), he recalled that the Thirty-sixth World Health Assembly had adopted resolution WHA36.30 underlining the fact that tuberculosis still constituted an important health problem in many Member States and that the programme should therefore be greatly strengthened. Furthermore, tuberculosis was a disease that could be prevented by BCG vaccination in childhood, and could be cured, because treatment at the present time was quite effective provided that cases were found in good time and identified.
by bacteriological methods. He would not deal at length with the problem, but would stress that the disease, which was still the cause not only of illness in Member countries but also of death in some of them, should not be ignored.

With regard to leprosy (programme 13.9), he reminded the Committee that at that very moment there were between 10 and 11 million cases of leprosy in 80 countries of the world. A disease for which, although much was known, control measures were not easy to implement because cases required prolonged treatment, even though new drugs had been introduced permitting the treatment to be either simplified or somewhat reduced in length, must be a source of great concern. However, hope lay in the progress being made in the development of the new vaccine, currently being field-tested. The Secretariat would reply at the proper time to the detailed questions which members of the Committee would no doubt ask.

Concerning programme 13.10 (Zoonoses), he pointed out that it was one of the programmes of the block currently under consideration to which the most extrabudgetary funds had been allocated, representing for the biennium 1986-1987 an estimated US$ 16 717 000. In addition the regular budget for the programme had been increased by about 21%, giving a figure of approximately US$ 3 500 000 for that biennium. The programme was concerned basically with such diseases as rabies, leptospirosis, some parasitic zoonoses, such as echinococcosis, and problems arising from food poisoning as a result of the consumption of foodstuffs derived from infected animals. Some regional or subregional centres were being set up, although with considerable difficulty; in Africa one had already been established and it was hoped to establish another; but he drew attention to the fact that those centres were associated with difficulties of a technical and administrative order which had to be taken into account if frustration or failure were to be avoided. He also pointed out the importance of the Organization's coordinating role in the research being carried out under the programme. Many problems demanded research, especially applied research, which in addition required large-scale international collaboration and discussion, especially between developing countries.

Moving on to sexually transmitted diseases (programme 13.11), which had so far been a low-budget programme, he said that the question of the acquired immune deficiency syndrome (AIDS) had been discussed at length in the Executive Board; the Organization obviously had a leading role to play, based on the current state of knowledge in providing guidance to countries. The matter was important, not only because of the increasing number of cases, but also because in the immense majority of them the outcome was, in the long term, fatal, and all governments and people in general were extremely concerned about the problem. The meeting held in Atlanta, Georgia (USA), in April 1985, had been informed of the progress made, from which it would seem that some case-finding was possible, using certain diagnostic techniques such as those for detection of antibodies or the virus in blood, among blood donors, for example. Much concern, on many grounds, would undoubtedly be expressed in the Committee and the Secretariat would be able to respond much more effectively than he himself was able to do in so brief an introduction.

Finally, he wished to bring to the Committee's attention two points relating to programme 13.13 (Other communicable disease prevention and control activities). The first was the new programme for vaccine development. He considered that initiative by the Director-General and its presentation in the budget as of outstanding importance in that it could have a major impact in providing effective means of control in the field of immunization. Examples of the important research in progress were the improvement of poliovirus and rabies virus vaccines and the development of a vaccine against hepatitis A and the improvement of the vaccine already available against hepatitis B. The Board believed that the application of modern biotechnology, including monoclonal antibody techniques, to disease control was of the greatest importance in order to provide countries with effective tools for that purpose. The second point he wished to highlight was the inclusion in programme 13.13 of the whole process of integration of the prevention and control of all communicable diseases into primary health care. That most relevant feature should be furthered through the activities of the programme and should, in turn, provide the tools for evaluating disease control programmes not only with regard to their specific functions and objectives, but also in respect of the process of their integration into primary health care, thus being of the utmost importance in the development of monitoring and evaluation methodologies.

Professor MATTHEIS (Federal Republic of Germany), commenting on programme 13.10 (Zoonoses), said that in recent years zoonoses and related foodborne diseases had become of growing importance, in both developing and industrialized countries, not only from the point of view of human health but also from the economic point of view. Her delegation fully supported the programme targets.

In the situation analysis (paragraph 7 of the programme statement), it was mentioned that in the Federal Republic of Germany a ten-fold increase in the number of cases of human salmonellosis had been recorded during the last decade. The main reason for that increase, however, was an improvement in the recording system, which was now more complete.
In support of the programme, the Federal Republic of Germany had hosted a number of WHO working groups and conferences dealing with zoonoses control, economic consequences and preventive aspects. The main aim was to improve the surveillance system, especially with regard to salmonellosis, by measures adapted to practical needs and with little increase in cost.

As had already been mentioned in the discussion on food safety (programme 11.4), a close linkage between the two programmes was absolutely indispensable.

The importance attached to the programme by the Federal Republic of Germany was also shown by the fact that five WHO collaborating centres with zoonoses-related terms of reference were being supported in the Federal Republic; they included the rabies surveillance and research centre, the collaborating centre for research and training in food hygiene and zoonoses, and the centre for research on neurological zoonoses.

In view of the importance of that part of the programme, she regretted that there was a decrease in the appropriation at intercountry level in the African, South-East Asia and European Regions. It seemed somewhat surprising that, in the descriptive part of the budget, increased importance was ascribed to zoonoses, while in the financial part the appropriation was decreased.

The Mediterranean Zoonoses Control Programme, in which many countries had invested considerable financial resources for several years, was no longer mentioned, and she asked for information on the future of that programme.

In view of the epidemiological situation, which did not justify any decrease in allocations, the Federal Republic of Germany would continue its support under the Voluntary Fund for Health Promotion for the zoonoses programme, and was willing to cooperate in any way that would promote that programme.

Professor COLOMBINI (Italy), referring to zoonoses (programme 13.10), said that a WHO collaborating centre had been established at the Istituto Superiore di Sanità in Rome, which received considerable funding from the Italian Government. The centre concentrated on the control of zoonoses and foodborne diseases in Mediterranean countries. The Italian delegation considered that particular attention should be given to the control of salmonellosis and other foodborne diseases, taking into account the complexity of the chain which began with animal feedstuffs and ended with human food. Intersectoral cooperation was essential in tackling the problem. It was to be hoped that the Veterinary Public Health Unit and other WHO units would be able to stimulate activity in that area.

Dr TTDJANI (Togo) said that programmes 13.7 to 13.13 were fully in line with Togo's major health concerns. Acute respiratory infections (programme 13.7) took a high toll in his country, especially of babies and children; however, facilities for diagnosis and early treatment were limited. More epidemiological and clinical research into such diseases was essential.

Tuberculosis was a major public health problem in Togo, and the health authorities were attempting to integrate tuberculosis control into primary health care. The national tuberculosis programme was based on prevention, early diagnosis, and treatment of all diagnosed cases. As far as possible, children were systematically vaccinated, as part of the Expanded Programme on Immunization. For two-and-a-half years Togo in collaboration with WHO had been conducting a field study on the efficacy of BCG vaccination in children who had been in contact with the disease. The study would soon be completed, and its results would be widely disseminated. His delegation was pleased to know that WHO and the International Union against Tuberculosis were to continue their training course on the epidemiology of the disease, held annually in Paris and Algeria.

Dr VIOLAKI-PARASKEVA (World Federation of United Nations Associations), speaking at the invitation of the Chairman, and referring to the programme on sexually transmitted diseases (programme 13.11), said that the acquired immune deficiency syndrome (AIDS) deserved special attention. The syndrome, with its high and cumulative mortality rate, had destroyed the confidence of the population in the public health services. Etiological and epidemiological studies had been carried out by various groups of research workers, but there was a need to coordinate research and to publicize the diagnostic and preventive measures available. Epidemiological studies so far had shown some differences. In some countries, more than 70% of AIDS victims were homosexuals, intravenous drug users and recipients of contaminated blood or blood products, whereas in others they were mainly heterosexuals. WHO should support research on simple, practical diagnostic measures and on development of an effective vaccine and help to set up a network of collaborating centres. The Weekly Epidemiological Record was already disseminating information on AIDS; WHO should continue that task and place greater
emphasis on health education. The Organization had already published a public information fact sheet in the series entitled In point of fact. The Federation would welcome any resolutions calling for international collaboration in that area.

Professor MULLER (Netherlands) said that programme 13.7 (Acute respiratory diseases) was hampered by the lack of preventive and therapeutic techniques. All that could be done at the moment was to define criteria for referral of cases, case management and health education. However, the first two measures might lead to an undesirable increase in the use of antibiotics. When appropriate vaccines had been developed, immunization should be dealt with under the Expanded Programme on Immunization. In view of its modest budget and its emphasis on acute respiratory diseases in childhood, the programme under discussion should perhaps be incorporated into a wider programme, such as maternal and child health.

The target of programme 13.8 (Tuberculosis) - an annual reduction of more than 2% in morbidity and in the risk of new infection by 1989 - would be difficult both to achieve and to quantify. Notification systems were inefficient and base-line risks were unknown in most countries. The 12-month standard treatment was often preferred to short-course chemotherapy because it was cheaper, but the short course reduced the probability of failure to continue treatment and would be more effective in reducing transmission if used in all smear-positive cases. The Netherlands delegation fully endorsed the proposed activities; the Netherlands provided a great deal of financial and technical support to tuberculosis control programmes in developing countries through both governmental and nongovernmental channels.

The target of programme 13.9 (Leprosy), namely for 90% of multibacillary cases to be under effective treatment by 1989, would also be difficult to achieve and quantify. However, the delegation of the Netherlands supported the planned activities and was glad that the Netherlands was in a position to provide economic and technical support to the programme.

Zoonoses (programme 13.10) affected both humans and livestock and were thus a double cause of suffering. Where wildlife formed the reservoir of infection, control and eradication were almost impossible. Zoonoses were also a great problem for impoverished urban populations who lived in slums infested with rats and stray dogs. There was a need for well-equipped control services and diagnostic laboratories, and for international collaboration to standardize laboratory methods. Training and education should not be ignored; zoonoses should be given a larger place in the medical curriculum.

Programme 13.13 (Other communicable disease prevention and control activities) covered many serious diseases, including meningococcal meningitis and viral hepatitis. The programme rightly emphasized the development of vaccines and simple methods of diagnosis. The development of a safe pertussis vaccine and a more stable measles vaccine was particularly important. WHO should continue to provide training courses in developed countries on the production of conventional vaccines and encourage the installation of production facilities in developing countries.

Dr LUVILIA (Zaire) said that, as mentioned in paragraph 5 of the programme statement for programme 13.12, human monkeypox had occurred mainly in Zaire. The trend in the incidence of the disease - 37 cases having been confirmed in 1982 and 80 cases in 1983 - justified the sustained efforts of the Government and WHO in its control and surveillance. His country had been glad to sign bilateral agreements with the Government of Japan aimed at continuing and strengthening those efforts, but it was disquieting to note that no budgetary resources had been allocated by WHO to the control of monkeypox in the above-mentioned programme. If assistance to the programme in Zaire were cut off, the success already achieved would be jeopardized. The Government of Zaire hoped that its collaboration with WHO would continue under the above-mentioned programme.

Dr KOINUMA (Japan), referring to the prevention of viral hepatitis in the context of programme 13.13 (Other communicable disease prevention and control activities), said that hepatitis B and chronic liver disease (including primary liver cancer) were a major health problem in Japan. The HBsAg (hepatitis B surface antigen) positive rate among the population had been estimated at 2.4%; 18% of HBsAg carrier women of child-bearing age also carried the e antigen (HBeAg). A total of 300 million yen (US$ 1.5 million) had been allocated from the national budget for 1985 for the prevention of maternal-infant transmission of hepatitis B virus. Under the proposed scheme, all pregnant women would be tested for HBsAg, and those found to be positive would then be tested for HBeAg. The estimated 10 000 babies born to HBeAg-positive mothers would be treated at public expense with hepatitis B immunoglobulin and hepatitis B plasma-derived vaccine, which had been authorized for use and was now available.

Japan's preventive approach to hepatitis B and primary liver cancer was the most cost-effective in the long run. WHO should increase its preventive activities aimed at controlling those diseases, especially since primary liver cancer was a preventable condition.
Dr HOPKINS (United States of America), referring to programme 13.8 (Tuberculosis), said that the proposed activities in the programme budget, which, except for research, had been given an increased share of regular budget funds, were described in rather general terms. His delegation believed that the programme reflected a realistic appraisal of the global tuberculosis situation and was moving in the right direction. Careful consideration should be given, however, to specific activities directed against that disease.

With regard to sexually transmitted diseases (programme 13.11), the Fogarty International Center of the United States National Institutes of Health intended to support the convening of two regional meetings, one in South-East Asia and the other in Africa, on the problem of endemic treponematoses. Those two meetings were intended as a follow-up to the International Symposium on Yaws and Other Endemic Treponematoses, held in Washington, D.C., in 1984, and to Health Assembly resolution WHA31.58, adopted in 1978, and also to a resolution adopted by the International Union against the Venereal Diseases and the Treponematoses in June 1984. All of those conferences had pointed to the alarming resurgence of yaws and endemic syphilis in several West African countries and to the need to improve relevant primary health care services for the affected populations.

His delegation commended the speed and quality of WHO's response to the grave and unprecedented challenge presented by the acquired immune deficiency syndrome (AIDS) and the proposed plan of action for 1986-1987. It was indeed ironic that, just as the Thirty-third World Health Assembly in 1980 was celebrating the eradication of smallpox, unknown to all at that time another deadly virus was beginning to affect mankind. Only the previous week the cumulative number of cases of AIDS reported in the United States had reached 10,000, and cases were also occurring in several developing countries.

It was now clear that AIDS was an actual or potential threat to both developing and developed countries. Reference to the disease, under the situation analysis in the programme statement (paragraphs 4 and 7), as a problem of the industrialized countries was thus inaccurate. Directly or indirectly, that disease was already, or would soon be, virtually every nation's problem. It was also apparent that the virus could be transmitted heterosexually, to partners of infected persons whether male or female; by an unlucky blood transfusion; or congenitally from an infected woman to her infant. Moreover, it was now known that, for each person with AIDS, as many as 30 or 100 more persons might be infected but asymptomatic. It appeared that an uncertain proportion of the latter might remain constantly or intermittently infectious indefinitely. Thus, while much progress had been made, much remained to be done. The programme statement was correct in pointing out that neither a cure nor a vaccine would soon be available. Meanwhile the only weapons for control were voluntary serological testing, counselling of high-risk persons, education of persons in affected communities, including health professionals, and the screening of donated blood.

Unfortunately, the disease was likely to be a topic of discussion at many World Health Assemblies to come.

Mrs GREWAL (India) said that her country attached great importance to family welfare and family planning programmes delivered through a package of health services related to maternal and child health, immunization, health education and family planning. Her country believed that that package would support its strategy for health for all by the year 2000.

To that end, India had, in its Seventh Plan, set as targets a birth rate of 21 per 1000 and an infant mortality rate of 60 per 1000 by 1990. By that date, there should be total coverage of the population by the Expanded Programme on Immunization and effective management of diarrhoeal diseases.

In addition to the family welfare programme, the highest priority had been accorded to leprosy, tuberculosis and blindness. A Leprosy Commission, under the chairmanship of the cabinet minister concerned, and a Leprosy Board, consisting of administrators, technical and social experts, had been established. Multidrug therapy in hyperendemic areas had been started and it was hoped before long to cover all the districts of the country in which leprosy existed at a rate higher than 5 cases per 1000. Her country had also authorized the field testing of the leprosy vaccine. Large amounts of anti-leprosy drugs would, however, be needed, together with continued WHO support. She noted that, because of continuous health education, leprosy no longer had the stigma formerly attached to it, and that more people were therefore voluntarily coming forward to take advantage of the medical services available. It was hoped that, with that change in attitudes, the leprosy control programme would proceed at a faster pace.

With regard to tuberculosis (programme 13.8), the situation was still rather difficult. While India had considerably increased its resource allocation for the control of tuberculosis, drug treatment was very costly and the nature of the disease was such that there was a large percentage of drop-outs, so that alternative strategies would have to be developed. Like other delegates, she stressed the need for long-acting drugs so as to break the transmission cycle.
India was well aware that acute respiratory infections (programme 13.7) caused a large amount of morbidity and were responsible for much infant and child mortality. It had already started pilot studies to study the logistics and the outcome of interventions. WHO's support in that respect would be highly appreciated.

Diarrhoeal diseases (programme 13.6) represented another area of importance. From time to time her country suffered from outbreaks of acute illnesses, such as gastroenteritis, dysentery and salmonellosis. It appreciated WHO's efforts to combat those diseases and would be grateful for further help in guarding against other micro-organisms which were liable to appear suddenly. Constant vigilance on that front would pay high dividends.

With regard to zoonoses (programme 13.10), India was very much alive to the high incidence of rabies in the country. It was trying to develop better and more effective human, as well as animal, vaccines against that disease.

At present, India had a high incidence of both communicable and noncommunicable diseases, but was concerned that, once communicable diseases were controlled, the incidence of noncommunicable diseases would increase, particularly in view of the increasing numbers of older people. The country was preparing for the future by reorganizing and reorienting its health services and the training of its health manpower. Pilot projects for in-depth studies had been started and it was hoped that the country would be able to meet the emerging needs in those areas. The main emphasis, however, had been on the prevention of disease through health education.

Dr KLIVAROVA (Czechoslovakia) said that, while diarrhoeal diseases were not a particular problem in her country, acute respiratory diseases were one of the main causes of absence from work and of illness in children. Czechoslovakia was, therefore, particularly interested in programme 13.7 (Acute respiratory infections) and in more rapid methods of diagnosis, more effective therapy, and timely information as to the nature of the pathogen, usually a virus, and its sensitivity to antibiotics and sulphonamides. In her country, respiratory infections were kept under constant surveillance. Czechoslovakia was interested in receiving information on those diseases not only from Europe but from other regions also.

As regards programme 13.10 (Zoonoses), she commented that in the programme budget there was no provision for systematic cooperation in the European Region. However, in Czechoslovakia, systematic work was being carried out on the prophylaxis of zoonoses, including salmonellosis, both by the sanitary and epidemiological service and by the state veterinary service. The veterinary school in Brno, which was a WHO collaborating centre, had in 1984 held a seminar for specialists from developing countries on problems related to zoonoses.

With regard to programme 13.12 (Smallpox eradication surveillance), Czechoslovakia, acting on resolution WHA33.4, had abolished compulsory smallpox vaccination in 1981, which had, of course, resulted in a change in the immunological status of the population. It was necessary, therefore, that WHO should continue the comprehensive clinical, epidemiological and laboratory study of certain difficult and doubtful cases. In future, it was also desirable that WHO should be able to call on a network of biological laboratories as a support for clinical diagnosis in Member States, thus ensuring their continued safety with regard to that infection. Many countries had halted the production of smallpox vaccine, so that it was necessary for WHO to continue to keep adequate stocks of it.

Czechoslovakia therefore supported the programme for continued epidemiological surveillance of the other orthopoxviruses, including monkeypox, which resembled smallpox, seemed to be spreading, and would need more attention in future, although at present it was restricted to certain tropical forest areas in Africa. Her delegation was not convinced that the resources allocated in the proposed programme budget for 1986-1987 would be sufficient to carry out all the 19 recommendations included in resolution WHA33.4 and at the same time to pursue the ecological studies on the spread of monkeypox.

Dr SULAIMAN (Nigeria) said that his delegation noted with satisfaction the progress made by WHO and the strategies it had adopted in the prevention and control of diseases (programme 13), and in particular of tuberculosis and leprosy (programmes 13.8 and 13.9). While it was gratifying to note that various vaccines against malaria, leprosy and schistosomiasis had been successfully tested, those vaccines were unlikely to be universally available.

His delegation was particularly doubtful about the rationale for the statements under the objectives and targets of the tuberculosis and leprosy programmes, namely that national control programmes for those diseases were to be integrated into the primary health care system in order to reduce the incidence and prevalence of those diseases. That would depend, amongst other things, on the availability of the relevant essential drugs. The mycobacteria of the two diseases were resistant to the comparatively cheap commonly used drugs, while most
developing countries could not afford the newer and more expensive ones. Even where those newer drugs were supplied, they were not available in sufficient quantity to combat the diseases. The administration of subclinical doses of drugs was the common cause of resistance of micro-organisms to those drugs. The use of inadequate dosages and insufficient coverage might therefore lead to resistance developing to the newer drugs.

It was perhaps not rational to continue to develop new and expensive drugs, which were unlikely to be made available to the needy, at a time when even existing drugs were not available in sufficient quantity because of their cost. In view of the economic difficulties faced by developing countries, a vicious cycle of drug resistance threatened to develop, with all its consequences. If the incidence and prevalence of tuberculosis and leprosy were to be reduced through primary health care, action had to be taken to ensure the supply of anti-tuberculous and anti-leprosy drugs at reasonable prices to the developing countries where those diseases were prevalent. Commending the efforts of nongovernmental organizations in combating leprosy, he said that the national leprosy control programme in his country could not have existed without their help. Nongovernmental organizations needed the drugs which his Government could not supply in sufficient quantity. He therefore called on WHO to give further consideration to cooperation with the developing countries in order to overcome the constraints which had been identified. Noting the increases in budget allocation with satisfaction, he said that the additional funds should be used to procure the drugs needed to control those diseases. He urged WHO also to seek extrabudgetary resources for that purpose.

Dr HELMY (Egypt) said that his delegation fully supported the proposed programme budget. Referring to the programmes on leprosy (13.9) and on other communicable disease prevention and control activities (13.13), he expressed his concern at the current incidence and prevalence of infectious diseases. The results of a recent survey carried out in three Egyptian governorates where leprosy foci were known to exist had shown that the disease was far more widespread than expected. Extensive surveys should therefore be carried out to assess the global situation with regard to leprosy and other infectious diseases.

With reference to treatment, he said that multidrug therapy was too expensive for many developing countries and that any help from WHO and other international organizations would be greatly appreciated.

The stigma attached to leprosy made it difficult to recruit personnel to work in that field. However, a vigorous campaign of information and education and the integration of leprosy detection and treatment services with other primary health care services would solve that problem.

He looked forward to the day when an effective vaccine against leprosy would be produced to control that disease.

Dr DE SOUZA (Australia) said that the acquired immunodeficiency syndrome (AIDS) was probably the most serious and certainly the most urgent public health problem confronting his country. He suspected that many developed countries also faced that problem, and that most developing countries would probably have to address the issue in the near future.

With the full cooperation of the health authorities in the States and Territories of Australia, the Federal Government had undertaken a major assessment of the impact of AIDS on the homosexual community, the blood transfusion services, haemophiliacs and other recipients of blood products, and people who used illegal drugs intravenously.

Although sexual relations were the most common mode of transmission, AIDS was much more than a sexually transmitted disease. AIDS virus antibodies were being found in female prostitutes and bisexuals in his country and had entered the heterosexual community. To combat the disease, a national strategy had recently been elaborated, involving not only the medical and scientific community and the health authorities, but also the Red Cross society, the haemophiliac society and other nongovernmental organizations. He emphasized that organizations representing homosexuals were also involved in that strategy.

A special national advisory committee on AIDS had been established under a lay chairman, prominent in the media world, to keep the public fully informed and to advise the Government on public reaction to AIDS.

At medical and scientific level, a national task force on AIDS had been set up to advise the Government, health authorities and health workers and their organizations on the latest scientific developments concerning AIDS and to provide technical advice. The task force, whose chairman was a distinguished Australian medical scientist, was spearheading the attack on AIDS.

At the technical level, a national reference centre for AIDS established at the Fairfield Infectious Diseases Hospital in Melbourne under the direction of a well-known Australian virologist had already evaluated the efficacy and diagnostic accuracy of a number of commercially-developed tests to identify antibodies to AIDS virus, and two of them had been selected for use.
Diagnostic kits had been supplied to designated hospitals, sexually transmitted diseases clinics and blood transfusion centres throughout Australia. The necessary laboratory equipment had been provided and technicians trained in the relevant scientific procedures. It had therefore been possible to introduce those tests simultaneously in all the States and Territories.

The simultaneous introduction of testing in hospitals, STD clinics and Red Cross blood transfusion services was an important part of the strategy, since the introduction of diagnostic testing only in blood transfusion centres could possibly result in persons at high risk of acquiring AIDS donating their blood solely in order to ascertain their AIDS antibody status. That would increase the danger of introducing the virus into the blood transfusion system.

With regard to blood products, such as the anti-haemophilic factor (factor VIII), the Commonwealth serum laboratory in Melbourne, which was a WHO collaborating centre, had over the preceding six months introduced a system of heat treatment (pasteurization), designed to eliminate the AIDS virus from factor VIII while ensuring the retention of adequate anti-haemophilic activity of the product. All factor VIII produced in Australia was currently treated in that way. His country did not use imported blood products.

All those measures and a carefully designed media campaign directed at the "at risk" groups, together with the obligation on all blood donors to complete a questionnaire on their health status and lifestyle, would, it was hoped, make it possible to control the spread of AIDS in his country. There was, however, no room for complacency and vigorous public health scrutiny was still necessary. His delegation welcomed the role of WHO in monitoring the world situation and its collaboration with national and regional centres on data collection, epidemiology and research activities in that important area.

The second aspect of disease prevention and control which the Australian delegation wished to address concerned chlamydia, which was responsible for a wide range of conditions, especially trachoma, sexually transmitted infection of the genital tract, and middle ear infections (otitis). Chlamydia had also been implicated in some cases of arthritis and uveitis.

In Australia, trachoma and chlamydial otitis mainly affected the aboriginal community. In recent years, much had been done in the prevention, diagnosis and treatment of trachoma and the blindness associated with it. A federally-funded programme, enlisting teams of ophthalmologists, had been highly successful and was currently administered through aboriginal organizations with the long-term object of eradicating trachoma from the aboriginal community.

The evolution of other forms of chlamydial infection was not so clearly defined. Research was continuing into the role of those organisms in the etiology of otitis media in aboriginal children and in arthritis and uveitis. There was still much to be learnt about sexually transmitted chlamydial infections of the urogenital tract, briefly referred to in the programme statement for programme 13.11.

Trachoma was a condition which had preoccupied WHO for many years and it was currently known that the causative agent, Chlamydia trachomatis and related organisms, was responsible for a much wider spectrum of morbidity. Whilst not making a plea for a special reallocation of WHO resources for research into chlamydial diseases, the Australian delegation hoped that WHO would bear in mind the high morbidity caused by chlamydial infections in developed and developing countries alike and would seek to support research programmes into chlamydial infections if so requested by Member States.

Finally, he drew the Committee's attention to a workshop on chlamydial diseases to be held at the Menzies School of Health Research in Darwin, Australia, from 17 to 20 July 1985. His delegation would be pleased to provide full details to all interested delegates.

Dr REZAI (Islamic Republic of Iran) said that his delegation fully supported programmes 13.7 to 13.17.

His country's experience in acute respiratory infections (programme 13.7) had shown that the major causes of fatalities, particularly among infants and young children, had been measles and pertussis complications. The mortality rate of measles prior to the mass vaccination campaign had been in the order of 17%. But as a result of the implementation of the Expanded Programme on Immunization there had been a considerable decrease in both morbidity and mortality from those diseases.

Tuberculosis was still a serious health problem in his country, and the number of positive smear cases had been put at 110 000. In connection with programme 13.8 he would like to know whether WHO approved and recommended the six-month courses of chemotherapy, or whether the subject was still under study. If so, he wondered what the percentage probability of relapse was following such a course of treatment.

As far as leprosy (programme 13.9) was concerned, although the total number of cases in his country was estimated at 35 000, only 11 000 cases had been detected and registered for
treatment. However, the social aspect of the disease caused greater problems than the disease itself. On the subject of chemotherapy for leprosy, he wondered what the most prevalent side-effects of pyrazinamide were, and how effective achedapsone could be.

With regard to zoonoses (programme 13.10), his delegation believed that, without close intersectoral collaboration between the Ministry of Health and other ministries and agencies involved, those diseases could not be controlled. His country was currently faced with many problems, particularly with brucellosis, rabies and cutaneous leishmaniasis, and he wondered whether WHO recommended "leishmanization" as one of the preventive measures for the control of the disease.

As far as sexually transmitted diseases were concerned (programme 13.11), he wondered whether the latest method of treatment for syphilis, worked out by the Centers for Disease Control, Atlanta, Georgia (USA), was still recommended by WHO.

Dr. SAVINYH (Union of Soviet Socialist Republics), referring to programme 13.10 (Zoonoses), recalled that the Alma-Ata Declaration on Primary Health Care stressed the importance, in the fight against human diseases, of the development of intersectoral cooperation; in that connection, the agricultural sector, including the veterinary services, could play an important role. The role of the programme in the last few years had increased on account of the increased international trade in livestock, animal products and feed, all of which could cause extensive outbreaks of zoonoses. Increasing numbers of such cases had been recorded in developed and developing countries alike, where they might be registered as serious diarrhoeal diseases, sometimes causing death, particularly among children. In the proposed programme for 1986-1987 the measures proposed were relevant and important and should be supported. Increased attention should be given to prophylactic measures against salmonellosis and other diseases affecting humans through the appropriate veterinary action. The Organization might usefully consider promoting a demonstration programme in a livestock-raising tropical country, isolated from the continent, with a high level of health care and veterinary services.

In programme 13.12 (Smallpox eradication surveillance) and particularly in connection with the recurrence of human monkeypox, the Organization should continue to promote scientific research and not cut down on measures for epidemiological surveys. The Soviet delegation supported the suggestions by the delegations of Zaire and Czechoslovakia in that connection.

With regard to programme 13.13 (Other communicable disease prevention and control activities) the proposed measures for 1986-1987 should be supported. Of particular relevance was the inclusion, in WHO's programme of action, of the development of new preventive and diagnostic techniques using modern biotechnology, which had not been sufficiently reflected in previous programmes. The Organization should continue to concentrate on existing vaccines and the development of new low cost and effective vaccines against the more dangerous and widespread communicable diseases. In view of the extent of viral hepatitis in the industrialized and in the developing countries, WHO's programme needed further development, particularly in the light of current scientific research in that area.

Professor SENAULT (France) said that in the programme on communicable diseases his delegation's attention had in particular been drawn to sexually transmitted diseases (programme 13.11) which were still highly persistent throughout society and therefore justified all measures taken to control them. AIDS was a matter of special concern to all countries, and now a major public health problem that was certainly likely to be a disease of the future unless the means of combating it were quickly found. In view of the knowledge of the virus that had been developed by researchers both in the United States and in France, there now appeared to be some hope of tackling the problem. In France, systematic serological testing of blood donors was being set up, and the collaborating centre for AIDS, in Paris, was at the disposal of all countries, particularly those in Europe, for the surveillance of cases submitted to it.

WHO was to be congratulated on its work under programme 13.11 and, particularly in relation to AIDS, on the linkage with programme 12.3 (Drug and vaccine quality, safety and efficacy), which demonstrated the excellent cooperation existing within the Organization.

Professor LAFONTAINE (Belgium), referring in particular to acute respiratory diseases (programme 13.7), which posed serious problems, said that the developing and the industrialized countries alike needed to achieve greater progress in laboratory work to enable the diseases to be identified and diagnosed more rapidly, and thus avoid indiscriminate recourse to antibiotics and chemotherapy. Furthermore, the problem of tuberculosis should not be forgotten: in the developed countries, doctors tended to overlook it entirely.
Much had been said about AIDS, and he was convinced, like others, that it was a disease of the future, perhaps to be considered in the context of the HTLV group, together with other retrovirus diseases that were not always transmitted sexually. In that connection, he stressed the importance of the free donation of blood, since the commercialization of that operation was known to have created problems. Moreover, he believed that the process of blood transfusion should be limited to the extent possible: transfusion was not always necessary and abuse increased the risks. More accurate diagnostic techniques were needed for AIDS. Although progress had been made in the identification of antibodies, positive reactions in persons not suffering from the disease posed extremely serious ethical problems; he would urge that greater efforts be made in research on techniques for identifying antigens as well.

Research should also be continued to find a less aggressive smallpox vaccine than the current one, especially as the vaccinia virus seemed likely to be useful as a vehicle for other vaccines, and because, although eradication had been achieved, a reverse could be sustained with such other diseases as monkeypox. Too little emphasis was being given to measles and rubella: in his view vaccination campaigns against those diseases should be more systematic.

As far as hepatitis B was concerned, the epidemiological studies that were under way at the International Agency for Research on Cancer (IARC) should be pursued, with particular reference to the link between hepatitis B and cancer.

Apologizing for re-opening the topic of malaria (programme 13.3) already discussed, he said that it would perhaps be useful to indicate, for purposes of chemoprophylaxis, the products that were officially recommended, and to avoid the inappropriate combination of certain products.

Miss FILIPSSON (Sweden) agreed that AIDS constituted one of the most serious threats to health in the future. Efforts should be made to disseminate information about the disease, especially regarding protection against infection and transmission, and methods should be developed to provide psychological support for those carrying this as yet incurable disease.

Dr REGMI (Nepal) said that rabies, viral encephalitis, salmonella and foodborne diseases were of great concern to his country. A project proposal for the control of rabies had been prepared with WHO assistance, and he hoped that it would be sympathetically received by the Organization and other bilateral and multilateral agencies. Pointing out that sheep-brain vaccine was used in Nepal, and that it would soon be possible to produce such vaccine locally, he asked whether that effort should be continued if sheep-brain vaccine were replaced by a newer, safer one. Should the reply be negative, Nepal would certainly require technological and financial assistance to produce the newer vaccine.

Other matters of particular concern to Nepal included the prevalence of viral encephalitis, problems caused by resistance to insecticides, poor environmental sanitation and, especially, the high cost of vaccines.

Dr PIO (Tuberculosis and Respiratory Infections), thanking delegates for their comments and suggestions, said that the programme on acute respiratory infections was making good progress. Awareness of the problem had increased markedly over the past five years, especially in developing countries where infant mortality rates were high. WHO, UNICEF and many multilateral and bilateral agencies were deeply concerned with child deaths from pneumonia. Child mortality rates were 30 to 70 times higher in developing countries than in industrialized countries. Etiological studies had shown that most cases of severe pneumonia were caused by two bacteria: Streptococcus pneumoniae and Haemophilus influenzae. Both could be treated with currently available antibiotics. Field studies had demonstrated the feasibility of reducing pneumonia in children through case management and health education. The programme did not advocate the widespread use of antibiotics, but their selective application in cases of moderate and severe pneumonia. In fact, the rational use of antibiotics would result in a reduction in the amount of antibiotics employed. Together with other units, the programme included surveillance of the sensitivity of bacteria to antimicrobials. It had been estimated that about 25% of mortality linked to acute respiratory infections could be prevented by the Expanded Programme on Immunization (EPI).

Resolution WHA36.30 on tuberculosis, adopted by the World Health Assembly in 1983, had requested the Director-General to collaborate with Member States in strengthening tuberculosis control programmes as a component of primary health care. There had been a total increase of 25% and a real increase of 12% in the regular budget, mostly directed to the country programmes. Many developing countries had requested funds for tuberculosis control from bilateral and international sources.

The delegate of the Netherlands had referred to short-course chemotherapy. He considered that the one-year regimen would remain the standard treatment for tuberculosis in
many developing countries because of the high cost of short-course chemotherapy. If the
trend towards lower drug costs continued, however, short-course chemotherapy might become
accessible to developing countries.

The delegate of the Islamic Republic of Iran had asked whether WHO approved the
six-month regimen for tuberculosis treatment. It had been fully tested; the relapse rate
was very low - less than 5% - and it was therefore recommended by WHO if countries could
afford it.

In reply to the delegate of Nigeria, he said that the targets of the tuberculosis
programme should be considered in conjunction with those of EPI, and that significant
progress could be expected by 1989, greater than the mere 2% annual decrease in morbidity in
the younger age groups and in the risk of new infections. The problem of procuring drugs for
the treatment of tuberculosis was part of the wider problem of essential drugs.

Dr NOORDEEN (Leprosy), in response to the comment by the representative of the Executive
Board regarding leprosy vaccine, said that a Scientific Working Group on Immunology of
Leprosy under the Special Programme for Research and Training in Tropical Diseases had been
working on the development of a vaccine against leprosy and had produced a candidate vaccine
based on killed Mycobacterium leprae derived from infected armadillos. Following successful
completion of animal studies on the sensitizing capacity and efficacy of the preparation,
studies had been initiated in man. The first trials had been completed among volunteers in
Norway, mainly to ascertain the sensitizing capacity, safety and acceptability of the
candidate vaccine, and it had been found satisfactory. A similar study had also been
completed in Malawi. The first vaccine trial using a mixture of killed M. leprae preparation and
BCG had been initiated in Venezuela. Clinical vaccine trials were also being planned for
Malawi and India.

In reply to the concern expressed by the delegate of the Netherlands regarding reaching
the targets included in the proposed programme budget, he said that extrabudgetary support for
the leprosy programme was being increasingly channelled towards the implementation of
multidrug therapy, and collaboration with several voluntary organizations was being
strengthened.

The delegate of Nigeria had rightly expressed concern about resistance to drugs. For
this reason, WHO had emphasized the use of multidrug therapy. While the newer drugs were
more expensive, they could be successfully administered over much shorter periods, thus
giving them a cost-benefit advantage over older types of treatment.

He endorsed the comment made by the delegate of Egypt on the need for leprosy surveys.
WHO had prepared a manual on sample surveys in leprosy which had in fact been used in the
survey in Egypt.

In reply to the delegate of the Islamic Republic of Iran, he said that dapsone
resistance and the relatively low blood levels of sulphone produced by acedapsone gave
acedapsone only a very limited value in the treatment of leprosy. Pyrazinamide was not used in
the treatment of leprosy as it had no effect on the disease.

Dr BOGEL (Veterinary Public Health) thanked the delegates for their comments on the
zoonoses (programme 13.10). Intersectoral resource mobilization was very important and the
Organization was deeply involved in the coordination of veterinary public health activities in
the health and agricultural sectors.

There had been a rapid increase in the resources directed to the prevention of diseases transmitted by animals in man's environment. Veterinarians and related professions outside
the health sector sought guidance from WHO and were ready to collaborate in improving human
health.

Regarding financial inputs, he said that major activities in the field of veterinary
public health were supported by the agricultural and other related sectors at country level.
Over 50 institutes and centres were collaborating with the Organization, in addition to the
specialized zoonoses centres. Intercountry and regional budget allocations showed a decrease
in a number of regions, which was, however, offset by an increase in country allocations.
Everything possible would be done to strengthen veterinary public health activities. In
addition, in collaboration with FAO and the World Veterinary Association, WHO was according
high priority to education and training, especially continuing training.

In reply to the questions on rabies control, he was glad to say that the programme
concerning human and canine rabies had attracted attention and support from various national
sectors, and that its activities were being coordinated with FAO, with the International
Office of Epizootics, and with funding agencies. 87 countries and territories were still
infected by canine rabies. At the moment, 31 of those countries were in the stage of
programme planning or execution within the framework of the WHO zoonoses programme.
Particular emphasis was being placed on vaccine research, quality control and technology
transfer; WHO looked forward to collaborating with the governments of Member States in the
latter area.
In response to the question raised by the delegate of Grenada at the ninth meeting, in connection with programme 12.3 (Drug and vaccine quality, safety and efficacy), he said that progress had been made with the development of an oral rabies vaccine for dogs and wildlife species. WHO would be pleased to collaborate with institutions in Grenada (possibly through the Caribbean Epidemiology Centre in Port-of-Spain) to study the applicability of the vaccine for mongooses which were the wildlife reservoir of rabies in Grenada.

The delegates of India and Nepal had referred to the high incidence of rabies in their countries, and in the region as a whole. A UNDP-supported project, which would include India, Nepal and four other countries, would be implemented from September 1985 to the end of 1986. The project would include health systems research, operational research, dog ecology research, comprehensive national programme planning, and the initiation of the first phases of self-reliance.

In the area of zoonotic diarrhoeal diseases, the delegates of Czechoslovakia, Federal Republic of Germany, India, Italy, Nepal and the Union of Soviet Socialist Republics had referred specifically to salmonellosis as a problem. The public health significance, as well as the great economic impact on developing countries, of that type of zoonotic infection was fully recognized by WHO. Unfortunately, the likelihood of an increase in salmonellosis and other zoonotic diarrhoeal diseases in those countries was growing. A major cause was the rapid increase in the mass production of animals, particularly poultry, which were an important source of human infection. FAO had forecast a four-fold increase in poultry production before the year 2000, and that development was likely to be a highly significant one, particularly in respect of salmonellosis. Meat, poultry, milk and eggs from infected animals and processed foods of animal origin contaminated during processing contributed to a great extent to the high incidence of the disease. Moreover, infected animals, especially in rural areas of developing countries, were an important source of faecal contamination of drinking-water by salmonella, as well as by other causative agents of diarrhoeal diseases. The Organization's accumulated knowledge of the epidemiology of those diseases, and the preventive technology for dealing with them, were contained in guidelines on prevention and control of salmonellosis issued by WHO. Salmonellosis control programmes should include the whole fertilizer-feed-food-waste chain. Only through a comprehensive approach could WHO hope to give effective help to countries.

The comments by the delegates of Czechoslovakia, the Federal Republic of Germany, the Islamic Republic of Iran and the Netherlands had raised the question of improving intersectoral cooperation. That was indeed essential at national level, and an important problem in many countries. WHO was in the process of promoting health systems research in an effort to find a solution, some of the problems being systemic. Likewise, at international level, coordination of activities with related programmes was crucial and those of the zoonoses programme would be closely linked with those under diarrhoeal diseases (programme 13.6) and food safety (programme 11.4). Cooperation with sister organizations and other institutions had been most fruitful and had had a noticeable impact on national services. Joint meetings at secretariat level and mutual invitations to regional and global governing bodies, as well as technical discussions on animal disease surveillance and on training, had become normal practice.

Dr ASSAAD (Director, Division of Communicable Diseases), replying to the question of the delegate of the Islamic Republic of Iran regarding sexually transmitted diseases (programme 13.11), said that treatment regimens for syphilis had been reviewed by a WHO scientific group on treponemal infections in 1980 and were contained in the group's report. They had subsequently been reviewed and would be incorporated in the sixth report of the WHO expert committee on venereal diseases and treponematoses, which was being prepared for publication in the WHO Technical Report Series. The treatment of choice for venereal syphilis continued to be a long-acting benzathine penicillin at a dose of 2.4 million units in a single injection for early infections and three injections weekly for late syphilis. For cases of neurosyphilis, other injectable penicillin preparations were preferred. It was important to note that treponemes had remained very sensitive to penicillin. For endemic syphilis (bejel) the currently recommended treatment regimen was 1.2 million units of benzathine penicillin in a single injection.

In regard to activities under smallpox eradication surveillance (programme 13.12), WHO was keeping up a very intensive study of the reservoir of monkeypox infection, with the help of the Governments of Zaire and Japan and of WHO collaborating centres. Within the network of those centres, the Organization was carrying out an intensive study of monkeypox virus. Monkeypox was a zoonotic disease which spilled over into man every now and again. The

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increase in reported cases in certain African countries, especially in Zaire, during the years 1982–1983 had probably been a reflection of intensive surveillance, and he was grateful to his colleagues in Zaire who had borne the brunt of the work of that surveillance. During 1984, the number of cases appeared to have levelled out, but WHO would keep an eye on the situation because of its obligation to give full information to the world on the matter. The Organization also had a committee on orthopoxviruses to advise it on further steps to be taken in that regard.

On the question of hepatitis B in the context of programme 13.13 (Other communicable disease prevention and control activities), it should be noted that nearly all WHO regional offices had set up task forces to develop regional programmes, since the epidemiology and control of the disease might be very different from one region to another. In the developing countries, infants and children were infected very early; in Africa, possibly within the first year of life, and in countries in South and East Asia infection might be passed from mother to infant. In the control of hepatitis, good medical practices were essential, especially the use of sterilized or disposable syringes and needles. Vaccination still remained one of the most important weapons against the disease, especially where infants and children were concerned.

WHO had an intensive programme for hepatitis B vaccine development and vaccine trials to combat the disease. Together with the Government of Burma, it had been carrying out studies on transmission from mother to infant, using vaccine alone instead of immunoglobulins plus vaccines. A large-scale demonstration vaccination programme was planned in coordination with the Government of the Gambia, the International Agency for Research on Cancer (IARC) and the British Medical Research Council to investigate whether vaccinating children with hepatitis B vaccine derived from plasma would really affect the chronic hepatitis picture, and eventually that relating to liver cancer. The study had been generously supported by the Italian Government, vaccine producers, and other agencies.

WHO was taking the lead in the development of hepatitis B vaccines produced in yeast; an article on that subject had appeared in the Bulletin. The eight vaccine producers of hepatitis B in yeast had agreed to supply their vaccines to WHO for an international collaborative study to characterize the vaccine. The provisional requirements were already in preparation, and were now being reviewed by an independent panel of scientists; he hoped they would soon be submitted, through the Biologicals Unit, to the Expert Committee on Biological Standardization. The Biologicals Unit had recently convened a meeting on continuous cell lines as substrates for vaccines, which would be useful in keeping a watch on hepatitis vaccine produced in those substrates using DNA recombinant technology, particularly in Chinese hamster ovaries. It was hoped that that method would produce what could be considered an ideal vaccine, both cheap and highly reliable. However, care had to be taken to ensure the safety of the vaccines.

WHO's vaccine development programme was progressing very favourably. US$ 1.4 million had been spent in supporting research in the most advanced biotechnology to help to develop a vaccine to combat respiratory viruses, hepatitis A, and dengue, and to create new vaccines to deal with tuberculosis and encapsulated bacteria, with special emphasis on meningococci. Many other vaccine development activities were in progress; a pertussis vaccine development programme was going forward, and scientists, supported by WHO, were conducting laboratory investigations of the Japanese acellular vaccine. A large-scale clinical trial of that vaccine would be carried out early in 1986 by the Swedish authorities. Other vaccines in the process of development would be considered by the Scientific Advisory Group of Experts, which managed the vaccine development programme; they included other rabies vaccines and flavivirus vaccines, such as those against dengue, yellow fever and Japanese encephalitis. In the utilization of that biotechnology, a very fast reagents programme would be developed.

The delegate of Belgium had mentioned the use of vaccinia virus as a vector; that was being treated as a promising but as a new product, and safety would have to be taken into consideration.

Finally, the problem of the spread of AIDS had been mentioned. Following a major international conference in Atlanta, Georgia (USA), in April 1985 WHO convened a consultation, attended by scientists, epidemiologists, public health administrators and laboratory workers, specifically to advise it on how to develop a programme to deal with the disease. That consultation had ended on Friday, 19 April, and its conclusions and recommendations had been published in the Weekly Epidemiological Record by 26 April.

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2 Weekly epidemiological record, 60(17), 129 (1985).
was, inter alia, recommended that a network of collaborating centres with special expertise in the field be established to assist in training staff, the provision of reference panels of sera, and the evaluation of diagnostic tests, and to advise on the production of working reagents. The centres would also assist in the preparation of educational material, and in planning studies to determine the natural history of the disease and the extent of infection in different parts of the world. WHO had already taken action on the first of the recommendations, and was currently in correspondence with a number of countries on the problem. He hoped that by the time of the Executive Board's session in January 1986 he would be able to furnish much more positive information on how the problem was being dealt with.

The meeting rose at 11h30.
Fourteenth meeting

Friday, 17 May 1985, at 14h30

Chairman: Dr D. G. MAKUTO (Zimbabwe)

Proposed Programme Budget for the Financial Period 1986-1987: Item 22 of the Agenda (Documents PB/86-87 and EB75/1985/REC1, Part II) (continued)

Programme Policy Matters: Item 22.2 of the Agenda (Documents PB/86-87 and EB75/1985/REC1, Part II, Chapter II) (continued)

Health science and technology - disease prevention and control (Appropriation Section 4; Documents PB/86-87, pages 200-274; EB75/1985/REC1, Part II, Chapter II, paragraphs 57-78; and A38/INF.DOC.7/7) (continued)

Disease prevention and control (programme 13) (continued)

The Chairman invited discussion on the last block of programmes under "major" programme 13 (Disease prevention and control), namely programmes 13.14 (Blindness), 13.15 (Cancer (including International Agency for Research on Cancer)), 13.16 (Cardiovascular diseases) and 13.17 (Other noncommunicable disease prevention and control activities). The Committee had before it a draft resolution on the prevention and control of chronic noncommunicable diseases.1

Dr BORGÔO (representative of the Executive Board), introducing the relevant programmes under programme 13, commented first on the issue of smoking and health, which the Executive Board had stressed as a priority for WHO and for Member States, and which had implications for many programmes, as was stated in paragraph 78 of the Board's report (document EB75/1985/REC1, Part II). It required joint efforts on the part of Member States, the whole population and the community, as well as public information and health education efforts.

Referring to programme 13.14 (Blindness), he said that stress should be placed on reducing avoidable blindness through simple preventive and curative measures. Prevention was also linked to the control of certain diseases and the promotion of the basic health conditions of the population, such as adequate nutrition.

Cancer (programme 13.15) was a major cause of mortality in a number of countries, including the developing countries. Much could and should be done to prevent cancer, along the lines indicated in paragraph 9 of the programme statement. Early detection was also very important, though not sufficient in itself, and follow-up treatment was essential, and should be standardized. One of the challenges regarding cancer was to establish a list of essential drugs. Difficulties to be faced included problems associated with the administration and delivery of care and the cost and length of treatment. An aspect of the programme that was important for humane reasons was pain relief, which was dealt with in paragraph 11. Noting that most of the funds allocated to the cancer programme came from extrabudgetary sources - some US$ 20 million as against US$ 3 million from the regular budget - he made a plea for all possible support to be provided to enable the programme to move ahead.

Cardiovascular diseases (programme 13.16) were a major cause of death in most countries, although there were promising signs that with the appropriate measures, such as had been taken in the United States of America, the mortality rate could be reduced. Special attention was given in the programme to hypertension, and research in that area was a priority. Advances had indeed been made in the medical and surgical treatment of cardiovascular diseases, and the advances in diagnostic and therapeutic techniques would be of great importance for the future.

1 For text, see p. 186.
In regard to other noncommunicable disease prevention and control activities (programme 13.17), particular attention was drawn to diabetes, which in many countries affected between 2 and 3% of the population over the age of 40. Although not many tools were available for primary prevention, early diagnosis and treatment could go a long way to preventing complications.

The Board considered that the budget allocation to the group of programmes under discussion needed reinforcing, and had requested the Director-General to allocate increased funds, particularly from extrabudgetary sources, but also from the Director-General's Development Programme, especially for cardiovascular diseases.

In conclusion, he stressed the value of the feedback from the governing bodies to guide WHO in its work; it was important that the Assembly should have sufficient time to provide that.

Dr MIGUES (Uruguay), referring to programme 13.16 (Cardiovascular diseases), said that such diseases were a major concern in his country, in view of the demographic developments. The population was aging and already 12% of the population were over the age of 65. That situation was characterized by a high prevalence of chronic and degenerative diseases. Cardiovascular diseases and cancer were the main causes of mortality, accounting respectively for 41% and 23% of deaths.

A nationwide family health survey conducted in 1983 with the collaboration of WHO and UNDP had shown that 23% of the population suffered from some chronic disease, primarily cardiovascular diseases, rheumatism and diabetes. That situation posed considerable problems of overloading and high costs to the public health and social welfare services. He wished to acknowledge, in that connection, the ongoing support received from PAHO for the research studies on chronic diseases to be completed in 1985. PAHO had also encouraged exchanges of experience and information, as well as periodic meetings, between the directors of chronic disease programmes in Argentina and Chile. The results of those epidemiological studies would be made available to the other countries of the region as they would probably undergo the same experience as Uruguay in future years.

The intention was to increase health programmes of education for health, based particularly on changing the habits of the population, and for prevention based on primary health care directed particularly to children and young people. Smoking, food habits and sedentary occupations were central to the prevention campaigns. It was of course difficult to change people’s life-styles and involved much time and money; his delegation hoped that, as in the past, it could count on the Organization’s support in that context. He was pleased to note the Director-General’s intention to expand the planning and implementation of national and regional preventive strategies regarding cardiovascular diseases for 1986–1987. He supported Dr Borgoño’s emphasis on the provision of further resources to implement programmes and develop bold and energetic activities in countries which, like Uruguay, were facing a somewhat gloomy future in the field of cardiovascular care.

Professor FORGACS (Hungary) said that in Hungary morbidity due to infectious diseases had considerably decreased as a result of systematic immunization as well as of improved living conditions. The crude mortality rate, however, had shown an upward trend for the past two decades. Within the overall mortality pattern, age-specific mortality rates for males aged between 35 and 59 years had markedly increased. About 50% of all deaths was due to cardiovascular diseases, but mortality due to cancer had also increased. Data on in-patient morbidity and causes of disability also testified to the increase in the incidence of cardiovascular diseases.

With regard to factors conducive to the development of cardiovascular diseases, rapid socioeconomic changes, population mobility – particularly the movement from rural to urban areas, discrepancies between new and traditional life-styles, and changes in the living and working environment, were felt to be just as important as primary risk factors (smoking, drinking, nutrition, and physical inactivity). In the 1970s up-to-date diagnostic and therapeutic tools had been introduced in cardiovascular services, and had considerably improved acute and chronic cardiovascular care. Continuous treatment of patients with cardiovascular diseases was provided at the primary health care level, and appropriate facilities were available for rehabilitation. As acknowledged in the situation analysis of programme 13.16, a considerable decrease in mortality and morbidity could only be achieved by changing people’s life-styles. In conformity with the recommendations of the conference organized by the Regional Office for Europe in 1984, particular emphasis was laid on increasing the efficiency of coronary disease prevention. In recent years Hungary had conducted a few pilot studies, in close cooperation with WHO, in order to identify measures that might be used in its national health strategies. That research acquired increased importance in 1984 when Hungary began participating in the Regional Office for Europe’s
integrated programme for the prevention of noncommunicable diseases. More recently, multisectoral committees had been established at both national and county level with the aim of promoting healthy life-styles by mobilizing the participation of community organizations, various nongovernmental organizations, educational institutions and work-places. Bearing in mind particularly the importance of cardiovascular disease, his delegation gave its full support to the draft resolution before the Committee.1

Dr SAVEL'EV (Union of Soviet Socialist Republics), referring to programme 13.15 (Cancer (including International Agency for Research on Cancer)), stressed its great importance for all countries. Its significance for the developing countries would continue to grow with an increase in life-expectancy and the successful fight against communicable diseases. He supported the emphasis on prophylactic measures, the development by countries of national programmes for the control of malignant tumours and the integration of control measures within the primary health care services. Since his country was a member of the International Agency for Research on Cancer and took part in the detailed discussion of the Agency's programme at the meetings of its statutory bodies, he would not discuss the Agency's activities in detail but merely state that his delegation supported their basic orientation.

His remarks in connection with cancer applied equally to programme 13.16 (Cardiovascular diseases). The rapidly increasing importance of those diseases should be appropriately reflected in the budget; in fact, the allocations for the 1986-1987 programme were 14.83% less than for the previous biennium.

With regard to programme 13.17 (Other noncommunicable disease prevention and control activities), his delegation noted with satisfaction a modest increase in the budgetary allocations for the next biennium. In particular, he was pleased to note the elaboration of a coordinated, integrated approach for the control of a whole group of diseases. The aim was to protect and promote people's health and introduce prophylactic measures through positive changes in life-styles, mainly through the primary health care services. That type of activity was valuable for both developed and developing countries. He fully supported the recommendation of the Executive Board in paragraph 83 of its report that additional funds be allocated from the Director-General's Development Programme to strengthen programme 13.17.

Dr MARKIDES (Cyprus), referring to cardiovascular diseases (programme 13.16), said that, as a result of a project undertaken in Cyprus with the collaboration of WHO a few years previously, the number of cases of rheumatic heart disease in his country was now negligible. Nevertheless, cardiovascular disease represented a major health problem and cause of death in Cyprus, and the Government was planning to spend large sums for the purchase of sophisticated equipment for the diagnosis and treatment of heart cases. But heart diseases were preventable, and more emphasis should be placed on the prevention aspects. Research should be intensified on harmful factors, such as smoking, high blood pressure, and food habits. Blood pressure was the chief factor in cardiovascular accidents and myocardial infarction. Yet some 50% of all hypertensive cases were undiagnosed; only 50% of the known cases were under treatment, and only about half of these were being properly treated. Epidemiological research on blood pressure was required in his country. His delegation firmly believed that it was more profitable to invest more resources in preventive medicine than in buying expensive equipment which would be obsolete within a few years. His delegation strongly supported the draft resolution before the Committee,1 and also supported the proposal to allocate additional extrabudgetary resources to the programme.

Regarding programme 13.17 and diabetes in particular, his delegation was gratified to note the assistance to countries in using modern standardized methods and technology for prevention and early detection. His Government was planning a project similar to that in Malta for the detection of unknown cases of diabetes; the technical and financial assistance of WHO would be needed in that connection.

Finally, the notion that hereditary diseases constituted a big problem about which nothing could be done was a misconception. In Cyprus, where thalassaemia had represented a major health problem, a community-based project carried out with the collaboration of WHO and using appropriate preventive technology developed by the Organization had resulted in the virtual eradication of the disease; there had been scarcely any new cases in the last two years. Cyprus was ready to share that experience for the benefit of other countries where the disease was widespread.

Professor MATTHEIS (Federal Republic of Germany) said that her country had made the prevention of cardiovascular diseases a priority area in a countrywide programme for the promotion of research and development for the benefit of health. A study was being carried

1 For text, see p. 186.
out over some seven years, with a considerable financial input. By controlling and reducing well-known risk factors among the inhabitants of selected intervention areas it was hoped that the study would demonstrate the possibilities of preventive efforts. Strong emphasis was placed on community participation in the programme which, if successful, would be extended. WHO's collaboration had been assured, and her country was most willing to cooperate with Member States carrying out similar projects.

Professor NAUMAN (Poland) fully supported the programmes under discussion. Regarding the prevention and control of cardiovascular diseases - which was one of his country's main objectives - it was understood that priority was to be given to the prevention of ischaemic heart disease. However, it was important to note that almost all countries were faced with increased mortality as a consequence of stroke. In that context, he wished to draw the attention of the Organization to the sudden death phenomenon which took a substantial number of lives during the first year following the onset of acute myocardial infarction. It seemed that the WHO MONICA project (multinational monitoring of trends and determinants in cardiovascular diseases) was concerned with only part of the problem. He suggested therefore that the WHO expert committee and the Organization's collaboration with the International Society and Federation of Cardiology should be concerned not only with preventive cardiology but also with curative problems.

Dr KLIVAROVA (Czechoslovakia) said that her delegation supported programme 13.15; cancer was the second most important cause of death in her country. Accordingly, Czechoslovakia was particularly interested in research and preventive activities, studies on carcinogenic substances, development of methods of early detection and the most modern methods of treatment, and not merely those for pain relief for incurable cases. On the question of financing, she considered that the regular budget resources did not reflect the needs of cancer-related activities, particularly in the developed countries. The linking of cancer - as well as cardiovascular diseases - mainly with smoking seemed an oversimplification, since several factors were involved.

Her delegation also supported programme 13.16 (Cardiovascular diseases). Czechoslovakia had been participating for some years in the MONICA project, with regard to the detection and treatment of hypertensive disease. The Institute of Clinical and Experimental Medicine in Prague, which was a WHO collaborating centre, had collaborated in several WHO projects. In spite of the fact that prophylactic measures against cerebrovascular and coronary heart disease were well known, there were difficulties in convincing people of the need to adopt a healthy life-style - to give up smoking, avoid excessive eating, adopt a healthy diet, and remain active. Despite health education efforts in Czechoslovakia no reduction in mortality from cardiovascular diseases had as yet been noted.

Her delegation welcomed the renewed emphasis given in programme 13.17 to the rheumatic diseases and diabetes. In that respect, she stated that her country was participating in WHO's integrated programme on noncommunicable diseases in the European Region.

She referred to the considerable surgical work, in addition to prophylactic activities, being carried out in her country, where there had been numerous successful transplants of the kidney, liver and pancreas. Seven heart transplants had been carried out with positive results, patients resuming a normal life after a few months. A number of institutes were taking part in a research programme on immunosuppressive drugs organized by a pharmaceutical manufacturer.

She strongly commended the draft resolution on the prevention and control of chronic noncommunicable diseases, her delegation being one of the co-sponsors.¹

Dr LEPO (Finland), commenting on the programme on smoking and health, described in paragraphs 6 to 10 and 20 to 25 under programme 13.17 (Other noncommunicable disease prevention and control activities), first emphasized its paramount importance with regard to the control of cardiovascular diseases and cancer, although it also was a factor in other diseases. It was his delegation's frank opinion, however, that that programme constituted far too weak a response to the challenge of controlling a worldwide epidemic, and required quite considerable strengthening in the future.

Referring to the table on "Global and interregional activities: Details by Programme and Activities" (Annex 3, page 423 of the programme budget), he said his delegation had been struck by the fact that there was no allocation whatsoever under the regular budget for the WHO programme on smoking and health. It would appear necessary that any programme of such importance should have a core funding from the regular budget so as to ensure proper programme planning, coordination and continuity. Furthermore, in connection with the

¹ For text, see p. 186.
programme content and priorities within the programme, there seemed to be a clear discrepancy between the text of the programme statement (paragraphs 20 to 25 under programme 13.17) and the budgetary allocations shown in the above-mentioned table (page 423). Moreover, if he interpreted the table correctly, all extrabudgetary funds anticipated for the forthcoming biennium were to be used for research, since they were listed against research activities.

On the basis of national experience, his delegation's firm opinion was that the real need was not for more research, but for action towards a comprehensive smoking control policy, for which research in the various disciplines concerned had already brought enough scientific evidence to light. Priority should be given to policy analysis, policy planning and policy implementation and evaluation. In his delegation's opinion it was indeed noteworthy that the Organization still lacked an effective action programme on smoking and health five years after the adoption by the Health Assembly of resolution WHA33.35, which had specifically requested the Director-General to develop an effective action programme, with clearly defined lines of responsibility and priority areas.

His delegation had noted with satisfaction that the Executive Board, in paragraph 78 of its report, had taken the issue of smoking and health very seriously, considering it to be one of high priority for the Organization and for virtually every Member State. His delegation strongly supported the Board's views, and would urge it to take up the issue as soon as possible. It would be desirable, following consideration of the matter in the Programme Committee and Board, for a progress report on an action programme on smoking and health to be submitted to a future World Health Assembly.

Dr GRECH (Malta) stated that his delegation fully supported programme 13 (Disease prevention and control). While it appreciated the high priority being given to the control of communicable diseases, as reflected in the budgetary provisions, it was somewhat disappointed by the limited extent of some allocations for noncommunicable disease programme activities, despite the ever-growing evidence that those chronic conditions also represented a real and costly public health problem, even in developing countries.

Referring to the situation in his own country, he informed the Committee that Malta had taken part in the MONICA project, and had also been participating in the noncommunicable diseases programme since 1984. Furthermore, over the past six years Malta had been carrying out a national diabetes programme, the implementation of which was being monitored and evaluated by WHO. Indeed, he quoted the opinion of a WHO expert from the United Kingdom who, following an on-the-spot assessment, had reported that the Malta project on diabetes was unique and offered an unrivalled opportunity to answer many questions with respect to care of diabetics in a community, and that its results would have a bearing on diabetes health care in many parts of the world, both developed and developing. In the light of those remarks, it was the more regrettable that, without belittling in any way the laudable efforts of WHO, Malta had in the main been obliged to operate that programme on its own, which had called for a major national initiative and imposed a financial burden, entailing the diversion of funds from other priority health areas. In the light of the experience gained in diabetes, which could be considered as a model chronic disease in relation to primary health care, and where health education, nutrition, life-style and community participation were all determining factors, Malta had now moved towards the integrated control of other noncommunicable diseases.

Accordingly, his country welcomed the reference under programme 13.17 (Other noncommunicable disease prevention and control activities), in paragraph 14, to WHO's collaboration in action programmes at country level in diabetes. His delegation wished to be included as a co-sponsor of the draft resolution presented by several delegations on prevention and control of chronic noncommunicable diseases.1 In addition, his delegation would make a plea to the Director-General to explore the possibility of finding extrabudgetary resources for allocation to cancer and cardiovascular disease prevention and control and other noncommunicable disease prevention and control activities (programmes 13.15, 13.16 and 13.17).

Professor COLOMBINI (Italy) joined previous speakers in emphasizing the importance of the part of the programme under discussion.

In regard to cardiovascular diseases (programme 13.16), which in his own country were the cause of almost 50% of all mortality, he merely wished to point out that, although preventive action necessarily had to be taken at the national level, it was vital not to overlook the considerable contribution which international support could provide towards concrete results, since almost all countries were concerned with the problem. On the basis of experience, emphasis should be placed on the need to alert public opinion to the need for proper nutrition, for refraining from smoking, particularly where young people were

1 For text, see p. 186.
concerned, and for early detection of the precursors. WHO could provide valuable help to national anti-smoking campaigns, since concerted international action should make it possible to achieve greater impact and overcome resistance.

Miss FILIPSSON (Sweden) first expressed her delegation's satisfaction with the priority being given under programme 13.15 (Cancer) to prevention and early diagnosis, especially for cervical, breast and oral cancer. In her own country, the results of a broad scientific assessment of screening by mammography had shown that breast cancer mortality in certain age-groups was significantly reduced by that procedure. She stressed the importance of the WHO global cancer pain relief programme, as it was essential that incurable patients should be able to be cared for in dignity.

With regard to WHO's programme on smoking and health, her delegation also fully endorsed the comments in paragraph 78 of the Board's report to the effect that smoking and health should be a high priority for the Organization and for virtually every Member State. For WHO support to be effective it was important for anti-smoking activities under the different programmes to be coordinated, and for measures envisaged under the smoking and health programme to be strengthened in the programme budget, as well as in the Eighth General Programme of Work.

Dr HOPKINS (United States of America) said that his delegation endorsed the views of the delegate of Finland and strongly supported the Organization's proposed efforts to discourage cigarette smoking. He agreed with the Executive Board's comments and that consideration should be given to assigning responsibility for smoking control to a single unit in WHO instead of, as at present, splitting it between three programmes - cardiovascular diseases, cancer, and other noncommunicable diseases - even though the health effects of smoking were relevant to all three. Nicotine, it should be stressed, was a highly addictive substance and strong counter-measures were therefore required.

Dr REID (United Kingdom of Great Britain and Northern Ireland) welcomed Dr Borgoño's introduction and fully supported the points he had made.

Cancer (programme 13.15) was a universal problem that in one form or another affected all Member States. Although continuing research was still required, there was an even more urgent need to apply the knowledge already gained on the causes of many forms of cancer. That was especially true with regard to the long-standing and incontrovertible scientific evidence implicating tobacco as a major cause not only of cancer but also of cardiovascular and other diseases. He endorsed the appeal by the delegates of Finland and the United States for more real action by WHO on smoking. Smoking was not only a component of the three subprogrammes under discussion, it was also of relevance in many others; a focal point within the Organization was thus required to deal with it, smoking being the biggest identifiable self-inflicted cause of death.

He welcomed the fact that the Director-General, in response to the recommendation of the Executive Board and the Health Assembly, had made US$ 500 000 available from his Development Programme in 1984-1985 to support activities under cardiovascular diseases (programme 13.16). Another welcome move was the development and continuation of the MONICA project, as much still remained to be learnt from the monitoring of trends in cardiovascular disease and relating them to the relevant risk factors.

In the context of other noncommunicable diseases (programme 13.17), he returned to the subject of tobacco as a major cause of needless death and suffering throughout the world. The Board's report on the programme budget, pointing out that diseases related to tobacco were related to a vast range of programmes, had stated: "It is hoped that the tobacco industry's insidious fostering of psychological associations between smoking and sport can be offset by WHO's 'Winners for health' project". That joint International Olympic Committee/WHO project was of major importance in the three broad fields mentioned by the Committee's President in his address to the Health Assembly - namely, physical exercise, nutrition, and personal responsibility. Smoking clearly came within the ambit of that joint project; he therefore asked for the Assembly to be provided with preliminary information on how the most effective use was to be made of the initiative and thereafter for full details to be supplied as they evolved to the Executive Board, which would report further to a future Health Assembly. That request was in keeping with the Board's intention, stated in its report, to devote further attention to the important issue of smoking and health. As the delegate of Finland had said, a major debate in the Health Assembly was called for in the near future.

Again in the context of programme 13.17, diabetes mellitus had now been recognized as a disease of universal importance and not merely a disease of affluent countries or affluent people. He commended WHO's intention to collaborate in diabetes action programmes at country
level. The views of the delegate of Malta on the subject had been of great interest. Diabetes in its various clinical manifestations provided a singularly good model of a malady highly susceptible to an approach based on primary health care. He welcomed the activities being jointly pursued by WHO and the International Diabetes Federation, which again provided a good model, in the present case, of the relationship between WHO and a nongovernmental organization. He hoped that WHO would continue to be willing and able to foster joint endeavours in the field of diabetes such as the programme statement mentioned.

His delegation was pleased to act as co-sponsor of the revised draft resolution on the prevention and control of noncommunicable diseases and particularly welcomed the Board's decision to recommend to the Health Assembly that programme 13.17 should receive supplementary funds from the Director-General's Development Programme.

Dr HASSOUN (Iraq) thanked the Director-General for the important information given on the programmes under discussion. He was particularly interested in programme 13.17 and stressed that the question of smoking and health should be given a high priority in every Member State, as the delegate of Sweden had also pointed out. Smoking was well known to be an environmental predisposing factor in the most important noncommunicable diseases. He, himself, having joined the ranks of the converted in 1961 and being still, 24 years later, a confirmed non-smoker, considered that a great deal more should be done in the way of educating the general public, starting such education in childhood. Medical professionals and other health staff ought to be a primary target for such education since they should set an example. Unfortunately, as those attending the Health Assembly year after year were aware, the Health Assembly itself in the areas outside the meeting rooms was heavily polluted by tobacco smoke, to an extent that even those such as himself with 24 years' abstinence from the habit were unwillingly turned into passive smokers. That was perhaps a minor point, but it would serve as a reminder that world health authorities and health leaders should be vigilant in pursuing preventive measures against the hazards of smoking, particularly in view of the aggressive and ever-increasing propaganda forced on the public in the modern world. Large sums of money were spent on such harmful advertising, more than any country's health budget could manage to set aside for its programmes. It was gratifying to see that the programme budget included an item on smoking control, but there was still a very long way to go and effort had to be sustained. He hoped that the Programme Committee of the Executive Board would devote a future report to the complex issues relating to smoking and health. He welcomed the support that the Sasakawa Memorial Health Foundation was expected to make available in 1986-1987 for a research project on passive smoking.

Mrs GREWAL (India) said her delegation fully supported programmes 13.15, 13.16 and 13.17. The activities they covered were of increasing interest to the developing countries, since, with the expansion of health care coverage, noncommunicable diseases were likely to become of increasing importance. Better detection techniques would also result in the identification of more cases at an earlier stage, thus resulting in greater demands on health services for treatment at reasonable cost.

In the case of cardiovascular diseases, her Government was particularly interested in making available diagnostic and therapeutic techniques at a reasonable cost to the general public. The present situation where high cost treatment was required abroad was quite unsatisfactory. Hence there was now a need for research into cheaper methods and equipment for treating such diseases that could in addition be used by less highly trained staff. More attention should also be given to preventive measures and techniques that were within the means of the developing countries. Noncommunicable diseases, once considered as diseases of the rich, were increasing in incidence in the poorer countries and people generally were becoming more aware of their ravages. There was also a need to change many habits, such as those related to eating and smoking, with the result that greater attention should be given to health education. As other speakers had also mentioned, more support should also be directed from extrabudgetary resources to research on noncommunicable diseases, which were claiming an increasing number of victims.

Dr DAOUDOU (Niger) said that although the developed countries had adopted legislation for the control of smoking, which among other things laid down standards to be met by cigarettes, the developing countries, which had not yet been able to introduce such measures and were without any control over the amount of harmful substances contained in tobacco, were being swamped with tobacco with a high tar and nicotine content, produced for the most part in the developed countries. He appealed to the developed countries to help the developing countries by making sure that the tobacco supplied to them met certain standards. He joined

1 For text, see p. 186.
previous speakers in commending the Director-General for his efforts on the control of smoking and expressed his delegation's support for programme 13.

Dr SULAIMAN (Nigeria), referring to programme 13.17, said that in his country and perhaps in all West Africa, one in five families had problems associated with hereditary sickle cell anaemia, which represented a severe burden on the family, the community and the health services. The present approach to that disease was one of palliative treatment to reduce pain, suffering and complications. The most appropriate preventive measure would be a family genetic screening and counselling programme and family planning. His delegation would like such a programme to be included, if possible, in an appropriate section of programme 9.1 (Maternal and child health, including family planning).

Family genetic screening and counselling would require laboratory investigation of families with appropriate education and advice on the need for family planning and health maintenance. There had been a lack of health education in hereditary disease control, although that was an area in which communities required basic scientific explanations and advice. Genetic counselling might be undertaken premaritally and in connection with maternal and child health services. Finally, collaboration in research at country level was required in developing simple laboratory screening methods at the primary health care level and standard guidelines on counselling.

Professor LAFONTAINE (Belgium) observed that there was a certain lack of logic in talking about the regulation of alcohol and tobacco. While those substances should of course be regulated, perhaps the ministries of finance of Member States should be asked to review the problem in order to ascertain on a cost-benefit basis where the real benefit for the population lay. That was particularly important in view of the prevalence of smoking and drinking among young women, with possible adverse genetic consequences.

The Committee had discussed the programmes on deafness and blindness: as he had already remarked in connection with deafness, reference should also be made to people who had poor eyesight and were hard of hearing, since many children and young people could have had a completely different life and career if their disability had been diagnosed and treated earlier.

With regard to nutrition and its possible relation to cardiovascular diseases, there could be no doubt that obesity promoted those diseases and also certain cancers. Accordingly, he pressed for attention to be paid to certain modern feeding habits, such as use of fast food shops, which were multiplying throughout the world and did not always make for a particularly well-balanced diet.

Among nutritional problems, reference had been made to diabetes: while he was very interested in diabetes, particularly in the associated genetic characteristics, he considered that goitre and cretinism should also not be neglected, since there were still areas where those diseases were tragically prevalent, and it would be useful to review WHO policy in that regard.

In connection with hereditary diseases, special attention should be paid to sickle cell anaemia, which prevented young people from marrying, killed children and incapacitated survivors. No treatment had yet been discovered although great hopes were placed on the molecular analysis of the human genome for all hereditary diseases. From the human and ethical point of view, however, it was important to bear in mind certain abuses that had been noted in various manipulations; ethical considerations would come to the fore in relation to the practical application of results.

Finally, in connection with occupational diseases, reference was always made to accidents occurring in workshops and factories and in agriculture, but practically no reference was ever made to the most frequent accidents, which were those which took place in the home and which were not covered by insurance or protected by trade union decisions. He begged WHO to give closer consideration to the dangers to which women, children, the handicapped and the aged were exposed in the home.

Dr LIU Xirong (China), referring to programme 13.15, said that his delegation endorsed the programme budget proposals for cancer prevention and control, since that disease represented a major public health problem in all Member States. Effective cancer control was indeed a concern not only of ministries of health, but of all peoples of the world. It was hoped that effective control measures would be found in the near future. WHO had given high priority to cancer control for many years, and its global programme on the subject had done much useful work in such areas as coordinating global cancer research, organizing information and technical exchanges, promoting international cooperation and helping Member States to integrate cancer control programmes in national health systems based on primary health care.
In view of the many tasks to be tackled in connection with cancer control, it was most important to establish the correct priorities, so that the human and financial resources might be used where they were most needed. In the 1986-1987 programme budget the Director-General emphasized the modernization and implementation of cost-effective cancer prevention and control measures, concentrating on helping Member States to formulate national cancer policies, cancer prevention through early detection, and effective therapy and pain relief. The Chinese delegation supported that well thought-out selection of topics and the resulting programme.

China also appreciated the valuable work done in recent years by the International Agency for Research on Cancer and hoped that that organization would continue to play its role in research on cancer epidemiology, organization of cancer registration and dissemination of information on cancer.

The results of many epidemiological investigations proved that the incidence of cancer was directly linked to the environment and life-styles. Recent further indications showed that one-third of all deaths due to cancer were tobacco-related; like many other Member States whose delegates had referred to the dangers of smoking, China was concerned with the problem and hoped that WHO would continue to provide Member States with the relevant information, materials and recommendations.

Dr. PAL (Pakistan) said that his delegation supported all the programmes under discussion, with special emphasis on prevention and early detection. It regretted, however, that those important programmes were not supported by commensurate budgetary allocations, which might perhaps be reviewed in the light of the comments made by various delegates.

Dr. REID (United Kingdom of Great Britain and Northern Ireland), referring to the interesting statement by the delegate of Iraq on tobacco smoking, suggested that replacement of the phrase "passive smoking" by the term "enforced smoking" in standard international verbal usage might make a psychological difference of considerable importance.

Dr. AL-MAZROU (Saudi Arabia) supported that suggestion. His delegation believed that smoking, together with alcohol and drug abuse, was certainly one of the most nefarious habits prevailing in the modern era, particularly among the young. With a view to controlling tobacco smoking, his country had set up a supreme council of eleven deputy ministers to develop a policy for tobacco smoking control. The council's recommendations included the complete prohibition of tobacco advertising in the mass media and prohibition of smoking in public areas. Moreover, a recent royal decree prohibited all advertising in hospital centres and health institutions. Similar measures in regard to smoking had also been taken by the Gulf States. Taxes levied on imported cigarettes had been increased, ceilings had been set for the permissible content of chemical substances in cigarettes, and methods had been developed to determine the quality of the nicotine contained in cigarettes. Despite all those efforts, however, smoking was still a scourge in Saudi Arabia and had to be controlled. Through the ministries of health and under the auspices of WHO real obstacles had to be raised to prevent the smoking habit from spreading. The matter was becoming increasingly urgent in view of the efforts being made to promote the marketing of tobacco and tobacco products in the Third World.

Dr. MGENI (United Republic of Tanzania) expressed support for the programmes under consideration, and associated his delegation with the concern about smoking and its effects on public health. Further financial support for that programme was required.

Smoking was strongly associated with the commercial profit motive and the lucrative nature of the tobacco trade. Since the issue was a sensitive one for economists, it would be interesting if some cost-benefit analysis could be made on the industry, bearing in mind that considerable use was made of heat energy for drying tobacco leaves. In the developing countries, where firewood was used in such processing, there could be a serious threat of deforestation to be added to those of air pollution and man-made diseases such as lung cancer.

Dr. GRABAUSKAS (Director, Division of Noncommunicable Diseases) said that the encouraging statements of delegates would guide the Organization in its further development and implementation of an overall noncommunicable disease prevention and control programme.

A number of delegates had rightly drawn attention to the burden placed by major noncommunicable diseases on developing and industrialized countries alike. As could be seen from the 1984 World Health Statistics Annual, a growing number of developing countries were reporting more on deaths caused by diseases that normally afflicted the affluent countries and less on those from infectious and parasitic diseases. The delegate of India had rightly observed that many developing countries which had not yet conquered infectious diseases were
now facing noncommunicable disease epidemics which made their situation even more serious. On the other hand, as various delegates had indicated, the funds allocated for the programmes concerned were inadequate. The Organization, in collaboration with countries, was doing everything that could be done with the limited resources available, including extrabudgetary resources.

The statement made by the delegate of Malta illustrated the importance of a strong national commitment and showed how much could be done with WHO resources, though limited in monetary terms, provided that they were used correctly and with initiative in pursuit of WHO's health-for-all strategy. The proper use of WHO resources as a catalyst to encourage national commitment and enlist international expertise was a good example of the primary health care approach in action. He expressed appreciation to the Government and Ministry of Health and Environment of Malta for their collaboration.

Delegates could rest assured that the diabetes programme activities would be considered as a model for other noncommunicable disease prevention and control. The Organization would be happy to continue and intensify that type of community health programme. He also assured the delegate of the United Kingdom that close working contacts with nongovernmental organizations such as the International Diabetes Federation (IDF) would be maintained and strengthened. That organization's noteworthy contributions to the WHO diabetes programme were not limited to its sizeable cash contribution but included an intellectual contribution. The joint programme monitoring and evaluation mechanism operated through the joint WHO/IDF Executive Committee on Diabetes was to be maintained.

In the light of recent knowledge and accumulated experience in the various programmes, and as requested by a number of delegates, WHO would continue to collaborate closely with countries, particularly in directing disease prevention programmes and gradually reshaping them, through research and development, into health promotion and health protection activities. In that connection, the guiding principle would be the healthy life-style concept introduced through primary health-care networks in full cooperation with other sectors of society. Increasing attention would be given to links between programmes and divisions. The strengthening of research and development, at least at global level, would therefore take place in the context of testing and implementing an integrated approach to the prevention and control of major noncommunicable diseases, carried out through national health systems based on primary health care. All those activities were aimed at developing the integrated noncommunicable disease control programme as part of community health work.

As had been stressed by many delegates, smoking and health issues were of the utmost importance. The activities in that connection might be used as an example of a package of genuinely integrated activities at various levels of society. That programme was being carried out in various programme areas within and outside the Division of Noncommunicable Diseases. The Organization agreed that greater prominence should be given to that important public health activity with its far-reaching impact on health. The guidance given by the delegates of Finland, Iraq, the United Kingdom, the United States of America and other countries with respect to priorities in the smoking and health sector were precisely in line with the WHO approach and programme framework. As recommended also by the Executive Board at its seventy-fifth session, smoking and health would be further considered by the Programme Committee of the Executive Board, which was to meet in October 1985 and for which the preparation of the report was well under way.

On the question of research mentioned by the delegate of Finland, the Organization agreed that more aggressive action rather than large-scale research was required. The activities referred to in the proposed programme budget document were but a few examples of the activities that were taking place. A great deal more was being done under other action programmes within the Division and in the Organization as a whole.

The recommendation made by the delegate of the United Kingdom with respect to joint action by the International Olympic Committee and WHO was extremely important, and was well taken. The plan of action was being developed and he hoped that the programme coordinator on smoking and health would give the matter more detailed treatment.

The comments of the delegate of Cyprus were well taken. That country's experience in thalassaemia control would be widely publicized, used and adopted for other countries where the problem existed. WHO would offer all possible assistance. A WHO training course on thalassaemia was to be held in Thailand in July 1985. Since over three million children with major congenital disorders, including hundreds of thousands suffering from thalassaemia and sickle-cell disease, were born each year, the countries concerned should be aware that the burden thus placed on families and on the health services could be avoided, with high cost-effectiveness, by the use of reliable community control measures. He thanked the delegate of Nigeria for having drawn attention to the problem of sickle-cell disease. As mentioned by the delegate of Belgium, no radical treatment was available for that disease, but the same approach as for thalassaemia, based on heterozygote screening, genetic
counselling and fetal diagnosis, when culturally acceptable, could be used. To facilitate that approach in developing countries, simple tests for congenital anaemia screening were being developed, together with fetal diagnosis in the first three months.

Careful note had been taken of the Belgian delegate's comments concerning the ethical issues of implementation of modern molecular technology, and due attention would be paid to that aspect in the meeting to be organized for the careful consideration of questions related to implementation of genetic control technology.

Referring to the comments of the representative of the Executive Board and several delegates regarding financial constraints, he expressed appreciation for the suggestion that the budgetary allocation for programme 13.17 should be increased. The suggestion had been noted and would be brought to the Director-General's attention.

Dr STJERNSWÄRD (Cancer) said that the comments of delegates, which were most helpful for the further development of the Organization's cancer control programme, would be carefully considered and acted upon.

Primary prevention was the most cost-effective measure against cancer. There was now sufficient knowledge to prevent one-third of all cancers, to cure one-third of patients if the disease was diagnosed early and suitable therapy was provided, and to give pain relief at least to allow death with dignity.

As pointed out by the delegate of Finland, there was no lack of knowledge concerning the effects of tobacco, whether smoked or chewed; action at the country level was what was needed. What was required was a political commitment on the part of Member States to apply strong legislation, regularly increase prices and provide health education. Recent WHO data showed that, despite the accumulated knowledge of more than 30 years about the health effects of use of tobacco, lung cancer had increased 200% in women and 116% in men in 28 developed countries between 1960 and 1980. The situation in the developing countries that were facing a smoking epidemic could thus be imagined. It was known that one-third of cancers in South-East Asia were self-induced—through tobacco-chewing—and avoidable. Yet the outstanding example of Finland, where age-adjusted mortality rates for males nationwide, together with the incidence for females, were declining, showed what could be done if the will existed. Experience in India had demonstrated that the two-thousand-year-old habit of tobacco chewing could be modified and life-styles could be changed for the better. Wherever WHO with Member States formulated national cancer control policies and selected priorities, primary prevention of tobacco use was included as the most cost-effective approach. It was highly rewarding to note that Chile, India, and Sri Lanka were doing exactly that, reallocating resources to effective priorities, using available funds for cancer control. No additional resources were necessary. The correct use of scarce resources, with the right strategy and the right priorities, could have a major impact on cancer even in countries with a limited budget for cancer control.

The positive comments on the Organization's global cancer pain relief programme, which was being well established, were appreciated. Draft WHO guidelines on cancer pain relief were currently being tested in 40 Member States. Pain was not inevitable but was almost always controllable. It was hoped that the pain control programme would become part of the health policies of Member States. He had been heartened to hear Dr Borgoño's introduction and his use of the word "humane". It would be some years before it would be possible to see the effect of action on the existing knowledge of primary prevention and therapy. Meanwhile, in developing countries, where the vast majority of the world's cancer patients were to be found, the only humane action that could be taken was to offer efficient pain relief.

Dr MUIR (International Agency for Research on Cancer) recalled that the International Agency for Research on Cancer had been founded by a Health Assembly resolution 19 years earlier. The Agency's programmes were presented in detail in the annual report. He drew attention to some of the Agency's activities which were related to points raised by delegates. Emphasis had been placed on the need for accurate information on the size of the cancer problem. IARC was collaborating with the Cancer Unit at WHO headquarters in trying to update estimates of the global burden of cancer, which had been published in 1984 for the year 1975, and which showed that the most common cancer in men was cancer of the lung, and in women, cancer of the breast. In women, lung cancer was the fifth most common. IARC would soon be publishing a compendium of relative frequency data for some 50 developing countries. In collecting data, IARC worked closely with cancer registries throughout the world. Confidentiality was proving to be an increasing constraint for cancer registries, reducing their effectiveness as a tool for the determination of the causes of malignant disease.

IARC had recently reviewed the risks posed by smoking tobacco, giving particular attention to enforced or passive smoking. Methods were being developed for the objective estimation of the effects of passive smoking through the determination of urinary cotinine.
Conscious that tobacco-chewing was on the increase and that the tobacco industry was fostering the idea that chewing tobacco was not so harmful after all, IARC had reviewed betel-quid chewing, so prevalent in the Indian sub-continent, and in particular, the nitrosation of the alkaloid arecoline in the areca nut. Some of the substances concerned were carcinogenic in experimental animals.

IARC was testing the hypothesis that much gastric cancer was linked to endogenous nitrosation of secondary amines in the stomach by looking at the effects of vitamin C on the formation of endogenous nitroso-compounds. Vitamin C might prove to be a relatively cheap method of prevention.

In collaboration with the Government of China, IARC had just completed an intervention study on the effect of a retinol-riboflavin-zinc preparation on the risk of precancerous lesions of the oesophagus. In China, oesophageal cancer was an even greater problem than lung cancer in the United Kingdom. IARC had also had a programme on the effects of nutrition in general on the risks of cancers such as those of the breast.

A large intervention study on the effect of hepatitis B vaccination was about to start in the Gambia, to determine whether the vaccination programme would lead in some 30 years' time to a reduction in the risk of primary hepatocellular carcinoma. The Government of the Gambia had given every encouragement, the Government of Italy had donated a generous gift of over US$ 4 million, and industry had contributed the vaccine. The technical expertise provided through the Division of Noncommunicable Diseases at WHO headquarters, the use of the Expanded Programme on Immunization for delivery, and support from the Medical Research Council of the United Kingdom, all augured well for the study.

IARC was also investigating the risks posed by chemicals in the workplace and the long-term effects of exposure to glass fibre, a substance being increasingly used as a replacement for the carcinogen asbestos.

The Agency was studying the long-term effects of pesticides in horticulture in Colombia. Studies on cervical cancer screening had been evaluated. The Agency believed that mortality could be reduced provided screening was nationwide.

IARC had studied the effects of treatments for cancer, including the long-term effects of the radiation used to treat cancer of the cervix, and was now examining the problems arising in patients who had undergone prolonged chemotherapy for malignant diseases. IARC placed great emphasis on training and education, with a fellowship programme geared to the training of epidemiologists in both developing and developed countries, and a programme of teaching courses. Such courses had recently been held in Argentina, Australia, Cameroon, Italy, Peru and Thailand, and one was planned for Malaysia in the near future. However, it was not enough to train epidemiologists; attention should also be given to their career prospects.

He expressed appreciation for the comments of the delegates of China and the Union of Soviet Socialist Republics concerning the programmes of the Agency.

Dr BÖTHIG (Cardiovascular Diseases) thanked delegates for their supportive and encouraging comments.

The delegates of Uruguay and India had referred to the growing prevalence of cardiovascular diseases in some developing countries. In that connection, he drew attention to the intensified programme for the prevention of cardiovascular diseases, initiated in 1983 in response to resolution WHA36.32. The programme had been finalized in 1984 and was now operational. It had two main components. The main objective of action for prevention of coronary heart disease, based on strategies proposed by the WHO Expert Committee on Prevention of Coronary Heart Disease,1 was to collaborate with interested Member States in the preparation of national prevention programmes. Guidelines on how to apply existing scientific knowledge on prevention of cardiovascular diseases in daily life had been proposed by the WHO Expert Committee on Community Prevention and Control of Cardiovascular Diseases, held in Geneva in December 1984. The report of that WHO Expert Committee would be published soon.2 The second component was the prevention of rheumatic fever and rheumatic heart disease in developing countries. Activities were currently managed from WHO headquarters, but it was anticipated that WHO regions and countries would soon assume responsibility for the management of programme activities. The proposed programme was designed to apply available knowledge and appropriate technology where it was most needed. It was essentially a service-oriented programme and not a research project.

2 In the WHO Technical Report Series.
With regard to primordial prevention, the prevention of occurrence of risk factors in developing countries, he noted the recommendation of a meeting of a major international organization of comprehensive cardiovascular disease control committees in developing countries that emphasis should now be given to methods for integrating cardiovascular disease control measures, linked to primordial prevention, with primary health care. The first combined meeting of investigators on the development of methodologies for cardiovascular disease prevention and control programmes in relation to primary health care would be held in June 1985 in Geneva.

The delegate of Cyprus had referred to hypertension research and control measures. A study group report on blood pressure studies in children would be discussed by the Executive Board at the forthcoming seventy-sixth session. The WHO Regional Office for Europe was responsible for most of the research on hypertension coordinated by WHO. One of the programmes, the audit programme, was aimed at monitoring the degree of community control of hypertension, with the help of the WHO collaborating centre in Goteborg (Sweden). Two other research programmes were supported by WHO. The INTERSALT project, initiated by the International Society and Federation of Cardiology (ISFC), was designed to examine the relationship of sodium and potassium excretion to blood pressure - some 50 centres worldwide were participating. The CARDIAC study was designed to examine the relationship of dietary factors to blood pressure and major cardiovascular diseases.

Several delegates had referred to the MONICA project. He was pleased to report that the project was developing smoothly. During 1984, sustained efforts had been made to streamline the management and quality assurance of features relating to the project - some 40 centres from 26 countries were participating.

He informed the delegate of Poland, regarding the problem of sudden cardiac death, that a WHO scientific group on the subject had been held in October 1984 and its report was being prepared for publication. The representative of the Executive Board and the delegate of India had referred to advances in diagnostic procedures. A WHO expert committee on appropriate diagnostic techniques in the management of cardiovascular diseases was to meet in 1986. WHO was collaborating with ISFC in organizing a number of task forces. One had met in 1984 to consider the nomenclature of coronary arteriograms. A task force on percutaneous transluminal coronary angioplasty would meet in the near future.

As the representative of the Executive Board and the delegate of the United Kingdom had said, members of the Executive Board at its seventy-fifth session had strongly favoured the continuation of adequate central support to the MONICA project and to the intensified programme for the prevention of cardiovascular diseases. He was pleased to report that the Director-General had released additional funds from the Director-General’s Development Programme for the forthcoming biennium, allocating US$ 85,000 to the former and US$ 110,000 to the latter.

Dr MASTRONI (Smoking and Health) welcomed the clear guidance given by delegates on the strengthening of activities regarding smoking and health.

He was pleased to report that an agreement in principle had been signed by the Director-General of WHO and the President of the International Olympic Committee, Mr Samaranch, to the effect that the two organizations should cooperate in promoting healthy life-styles, including proper nutrition, moderation in the use of alcohol, increased personal responsibility in health and, of course, avoidance of smoking, thus leading to better physical fitness and better health. In WHO, the Division of Public Information and Education for Health would be the focal point for such collaboration. The agreement was a very recent development and not many details were as yet available. Specific activities aimed at the general public as well as at sportsmen and athletes would be developed. World Health Day 1986 would have as its theme "Healthy living: everyone a winner" and would be the occasion for major action, particularly in trying to counteract the misconception fostered by the tobacco industry in its promotional efforts in linking cigarette-smoking with sports activities.

In response to the suggestion of the Executive Board at its seventy-fifth session, activities on smoking and health were to be submitted for the attention of the Programme Committee at its next session, with a view to future consideration by the Executive Board. A report on WHO's programme on smoking and health was being prepared for submission to the Programme Committee in October 1985.

CONSIDERATION OF DRAFT RESOLUTIONS

Prevention and control of chronic noncommunicable diseases

The CHAIRMAN drew attention to the draft resolution, submitted by the delegations of Great Britain, Iceland, Bulgaria, Canada, China, Cuba, Czechoslovakia, Finland, German Democratic Republic, Hungary, Ireland, India, Mauritius, Sweden, Union of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, and Viet Nam, on prevention and control of chronic noncommunicable diseases, which read as follows:

The Thirty-eighth World Health Assembly, recalling resolutions WHA29.49 and WHA36.32, which led to the rapid development of a long-term programme to control cardiovascular diseases, with special emphasis on research into prevention, etiology, early detection, treatment and rehabilitation;

Mindful of the Director-General's progress report on the Global Strategy for Health for All by the Year 2000, in which he underlines the growing importance of chronic noncommunicable diseases, notably those of the cardiovascular system, cancers and diabetes mellitus, as major factors adversely affecting life expectancy and health in general in both developed and developing countries;

Bearing in mind that information is accumulating that points to a number of features common to several noncommunicable diseases, such as their origins in and aggravation by tobacco smoking and other life-style factors;

Taking also into account the proposals regarding the application of existing knowledge to national health services made by the WHO Expert Committee on Community Prevention and Control of Cardiovascular Diseases, in the report to the twenty-fourth session of the UNICEF/WHO Joint Committee on Health Policy on the prevention of rheumatic fever and rheumatic heart disease, and by the WHO Study Group on Diabetes Mellitus, together with the recommendations of the WHO Meeting on Reappraisal of the Present Situation in Prevention and Control of Lung Cancer;

1. APPRECIATES the Organization's increasing efforts to coordinate scientific activities in the prevention and control of chronic noncommunicable diseases, and welcomes the results attained thus far;

2. CALLS on Member States:
   (1) to assess the importance of noncommunicable diseases in their countries;
   (2) where the problem is of high priority, to promote and introduce community studies with a view to arriving at population-centred measures to prevent and control cardiovascular diseases, lung cancer, diabetes mellitus, chronic respiratory and other noncommunicable diseases, and, where these measures are already being applied, to exchange information on their operation and on the training of relevant personnel;
   (3) to offer other Member States opportunities for training and further education in the community control of noncommunicable diseases as an integral part of existing health services, and to make information available on the national criteria applied in defining persons at risk, early detection, therapy and rehabilitation;
   (4) to make use of the latest findings in chronic noncommunicable disease control with the aim of devising, testing and introducing into existing health services models for the integrated control of several chronic conditions;

3. REQUESTS the Executive Board to consider the inclusion in the Eighth General Programme of Work, as a continuation and intensification of the Seventh General Programme of Work, of research and development aimed at the combined prevention and control of several noncommunicable diseases within health systems based on primary health care;

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1 See document WHA38/1985/REC/1, Annex 6.
2 Reports being published in the WHO Technical Report Series.
4. REQUESTS the Director-General, in view of the overriding importance of noncommunicable diseases in several countries in the implementation of their strategies for health for all by the year 2000:

(1) to intensify measures to promote the prevention of cardiovascular diseases, as an example for other noncommunicable diseases;
(2) to foster and support community studies aimed at the joint control of a number of risk-related noncommunicable diseases;
(3) to encourage particularly the coordination within WHO of programmes aimed at influencing risk factors closely related to individual life-styles;
(4) to ensure the availability of resources for the exchange of study protocols and experience among Member States involved in this initiative;
(5) to encourage and sponsor workshops in Member States so that information about the practical implementation of control programmes can be quickly exchanged.

He had been informed that the delegation of Malta wished to be included among the sponsors of the draft resolution.

Dr MÜLLER (German Democratic Republic), introducing the draft resolution on behalf of the sponsors, said that resolution WHA29.49 had stressed the promotion of research under a long-term programme on cardiovascular diseases and resolution WHA36.32 had called on Member States to pay particular attention to the inclusion in their national health plans of comprehensive measures to combat cardiovascular diseases. In recent years, ideas about an integrated approach to the control of chronic diseases or their risk factors had been crystallized and were reflected in paragraphs 74-78 of the Board's report, and in the summary record of the twenty-second meeting of the Executive Board at its seventy-fifth session. Since his country had useful experience in the field, and in order to support the integrated approach, it had submitted the resolution and was grateful to all who had supported it.

The resolution was designed to promote an integrated approach to several diseases which were major contributors to morbidity, mortality and invalidity, and its emphasis on prevention was in full accord with WHO's general programme. It was obvious that the concept it advanced could be adapted to various health care systems. Because a number of countries had valuable experience in respect of programmes to prevent specific diseases and to control noncommunicable diseases in general, there was a definite need for a more intensive exchange of experience and expertise: that was why the draft resolution suggested that consideration should be given to the inclusion in the Eighth General Programme of Work of the combined prevention and control of several noncommunicable diseases. His delegation had already pointed to the need to link research on health systems with other groups of programmes, and the resolution also represented an attempt to establish that link.

Dr GRECH (Malta) said that, because nutrition greatly affected the incidence of hypertension, cardiovascular diseases and diabetes, the words "including unbalanced nutrition" should be inserted at the end of the third preambular paragraph.

Dr MÜLLER (German Democratic Republic) said that the sponsors had no objection to that amendment.

The draft resolution, as amended, was approved.  

Collaboration with nongovernmental organizations in implementing the Global Strategy for Health for All

The CHAIRMAN drew attention to the draft resolution submitted by the delegations of Canada, Cuba, Finland, India, Zambia, and Zimbabwe, which read as follows:

The Thirty-eighth World Health Assembly, Recalling resolution WHA34.36, and reaffirming commitment to the implementation of the Global Strategy for Health for All by the Year 2000 through the solemnly agreed, combined efforts of governments, people and WHO; Mindful that the attainment of the goal of health for all by the year 2000 is an integral part of international social and economic development as well as a direct contribution to world peace;

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1 See document EB75/1985/REC/1, pp. 293-295.
2 Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA38.30.
Emphasizing the crucial need for a real partnership between governments, nongovernmental organizations and WHO in order to achieve the goal of health for all by the year 2000;

Recognizing the commitment of nongovernmental organizations and the extent of the resources which they can mobilize for the achievement of strategies for health for all;

Taking into account the conclusions and recommendations of the Technical Discussions held during the Thirty-eighth World Health Assembly on collaboration with nongovernmental organizations in implementing the Global Strategy for Health for All;

1. APPEALS to all nongovernmental organizations to support the strategies for health for all, and calls for their involvement and the increased use of national and international resources towards this end;

2. CALLS on the national nongovernmental organizations:
   (1) to commit themselves in practice to the implementation of the strategies for health for all by the year 2000;
   (2) to establish close collaboration with governments, in a spirit of partnership, for the implementation of national policies and programmes;
   (3) to encourage and support in all ways self-care and self-help groups at the community level for the effective implementation of primary health care;
   (4) to establish appropriate national coordinating mechanisms, such as national councils of nongovernmental organizations, to provide a focal point for nongovernmental activities in health and health-related fields;

3. URGES international nongovernmental organizations:
   (1) to take appropriate measures to further the collaboration between national nongovernmental organizations and Member States;
   (2) to collaborate with WHO and other international organizations in providing support and cooperation;
   (3) to coordinate their activities to ensure mutual support and cooperation;

4. CALLS on Member States:
   (1) to promote, foster and support the partnership approach by involving nongovernmental organizations in policy formulation and the planning, implementation, and evaluation of the national strategies;
   (2) to encourage and support the establishment of self-help and self-care nongovernmental groups at the community level, giving particular emphasis to women's groups, in order to implement primary health care approaches effectively;
   (3) to stimulate the active involvement of youth and student organizations, since these represent the generation that will be responsible for the world's health in the year 2000;
   (4) to encourage and support the establishment of nongovernmental coordinating or other appropriate mechanisms at the national level to facilitate mutual dialogue and close consultation on health matters;
   (5) to utilize the expertise and experience of nongovernmental organizations through consultation, and for this purpose prepare inventories of their resources, skills and collaborative activities with governments;
   (6) to facilitate the mobilization of adequate resources for the work of national nongovernmental organizations for health work;

5. REQUESTS the regional committees to consider ways and means of strengthening the involvement of national and regional nongovernmental organizations in the implementation of national and regional strategies for health for all;

6. REQUESTS the Executive Board to review the existing framework of WHO's collaboration with organizations in the nongovernmental sector, together with the existing rules and procedures, with a view to strengthening it and making it more effective;

7. REQUESTS the Director-General:
   (1) to pursue his efforts to promote the involvement of international nongovernmental organizations in the Global Strategy for Health for All;
   (2) to promote and support partnership activities of Member States, WHO and nongovernmental organizations for the implementation of strategies for health for all;
   (3) to review periodically the progress made in promoting and fostering collaboration between governments and nongovernmental organizations.
He had been informed that the delegations of Rwanda and Trinidad and Tobago wished to be included among the sponsors of the draft resolution.

Mrs TAGWIREYI (Zimbabwe), introducing the draft resolution on behalf of the sponsors, said that the need for such a resolution had been extensively debated during the Technical Discussions, which had consolidated the courtship between nongovernmental organizations, WHO and Member States. The courtship had now reached a point where a definite commitment to a lasting and fruitful partnership must be made. The resolution represented such a commitment. The sponsors were convinced that the essential elements for such a partnership already existed; the partners were fully aware of their respective strengths and weaknesses, they had no illusions about one another, but they realized that they needed each other if the goal of health for all by the year 2000 was to be achieved. Was there any better basis for a marriage? The sponsors did not think so and hoped that the Committee would approve the draft resolution.

Dr SULAIMAN (Nigeria) requested that his delegation be included in the list of sponsors.

Dr SAVEL'EV (Union of Soviet Socialist Republics) said that he wished to submit amendments designed to improve and strengthen the resolution and which he hoped would be acceptable to the sponsors. In paragraph 2(2), "health-for-all" should be inserted after "national". In paragraph 3(1), "in the implementation of health-for-all strategies" should be added after "Member States". In paragraph 3(2), "in health-for-all activities" should be added after "cooperation". In paragraph 3(3), "in health matters" should be added after "cooperation". In paragraph 4(1), "health-for-all" should be inserted after "national". In paragraph 4(5), "health" should be inserted after "collaborative".

Mrs TAGWIREYI (Zimbabwe) said that the amendments did not alter the substance of the draft resolution and that the sponsors could accept them.

Dr CHIDUO (United Republic of Tanzania) requested that his delegation be included in the list of sponsors.

The draft resolution, as amended, was approved.1

The meeting rose at 17h40.

1 Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA38.31.
FIFTEENTH MEETING
Saturday, 18 May 1985, at 9h00

Chairman: Dr D. G. MAKUTO (Zimbabwe)

1. FOURTH REPORT OF COMMITTEE A (Document A38/37)

Dr RAY (Secretary) read out the draft fourth report of the Committee.

The report was adopted (see document WHA38/1985/REC/2).

2. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1986-1987: Item 22 of the Agenda. (Documents PB/86-87 and EB75/1985/REC/1, Part II) (continued)

PROGRAMME POLICY MATTERS: Item 22.2 of the Agenda (Documents PB/86-87 and EB75/1985/REC/1, Part II, Chapter II) (continued)

Programme support (Appropriation Section 5; Documents PB/86-87, pages 275-291; EB75/1985/REC/1, Part II, Chapter II, paragraphs 79-81; and A38/INF.DOC./7)

Dr BORGANO (representative of the Executive Board) expressed the view of the Board that health information support (programme 14) was very important. Generally speaking, the quality of the documents and publications was quite good and had been commended in both the Health Assembly and the Executive Board. The Board nevertheless shared the Director-General's concern regarding the distribution of documents and publications, particularly as regards the need to ensure that they duly reached those who needed them most and that there was no breakdown in distribution at certain levels, either in the regions or in the countries themselves, to diminish the efficacy of that important and relatively high-cost operation. The Board therefore wished to emphasize the need to strengthen and improve the distribution of documents and publications to reach those who needed them most as quickly as possible. The role of the regions in eliciting support at the country level was therefore particularly important, both in regard to the global publications issued by headquarters and in regard to their own publications; most, although not all, of the regions had publications programmes which were of great value to the countries of the region.

The advisory panel on health and biomedical information, composed of health information experts from outside the Organization, would play an important role in assessing the need to revise publication policies and standards. Feedback from the panel could make an important contribution to enhancing the quality of an already good programme.

The discussion of the language services had revealed a feeling on the part of a number of countries that they were not always "interpreted" idiomatically in the various languages. There was accordingly a need for improvement and, to that end, for developing feedback from countries and for closer coordination of the language services. The Board considered the continuing application of computer-supported techniques to health information terminology to be very useful; the activity should be strongly supported and further strengthened.

The regular budget for the programme was approximately US$ 34 millions, while extrabudgetary funds amounted to US$ 8.5 million. Everything possible should therefore be done to rationalize the use of such a substantial amount of money and to evaluate publications which might have given rise to doubts on the score of quality, continuity and wider or more limited distribution.

Three points arose in connection with programme 15 (Support services). The first related to strenuous attempts that should be made to appoint more women to posts at responsible professional levels. Some discussion on the issue had taken place in Committee B. During the Executive Board's session in January, Dr Law, who had been asked

1 See summary records of the second meeting, section 6, and third meeting, section 3.
by the Director-General to prepare a study on the issue, had furnished a number of facts which might be of interest to the Committee. The Region of the Americas had exceeded the target and had achieved almost a 30% level in senior professional appointments for women. The average for the Organization as a whole and for the European Region had reached the target figure which had recently been changed. By contrast, the figure for the Eastern Mediterranean Region was only 7% while that for the South-East Asia Region was 12%, thus indicating that further efforts were needed if the goal was to be achieved and that there was still some way to go if what had been said in Committee B about the role of women in health and development was to be translated from words into facts.

He would also like to draw attention, in connection with programme 15.4 (Equipment and supplies for Member States), to the need for information of countries in connection with the purchase of equipment and supplies. Complete and timely information as regards not only the type of equipment, but also its complete specifications, would greatly facilitate the important role of the Organization in using country, interregional and global funds in an expeditious and efficient manner, thus ensuring the highest possible quality.

Finally, in regard to the support provided under programme 15 for the preparation of the Director-General's programme budget and reports on financial matters, he recalled that, on a number of occasions, the Board had made suggestions; it was important that they be taken into account in day-to-day action.

Health information support (programme 14)

Dr MAFIANBA (Cameroon) observed that, during the meeting of the Executive Board in January, the Director-General had expressed doubt as to whether Member States were making adequate use of the considerable amount of information generated by WHO. His delegation concurred with the general outcome of the debate which had followed, to the effect that WHO publications on the whole were doing good work in terms of information and continuing education, that there was no overlap, but that there was room for improvement. Some of those publications called for special comment. When the idea of launching World Health Forum had first been mooted, fear had been expressed that it would duplicate existing publications. That had not turned out to be the case, although the journal did seem to have the vocation of selling "health for all". The presentation and readability of WHO Bulletin, as well as World Health Statistics Quarterly, would greatly benefit from the pruning of some overly verbose articles. The International Digest of Health Legislation in its current form was less readable than previously and, during the last few years, the WHO Chronicle had lost some of its pristine scientific character.

It gave his delegation great pleasure to congratulate the editors of the magazine World Health for its lively presentation, easy readability and attractiveness. In that regard, the December 1984 issue devoted to schistosomiasis merited special mention and congratulations.

Recent Public Health Papers, and the publication on primary health care in China, were of a high calibre and had been prepared with great care.

He supported Dr Borgoño in deploring the total absence of authors from Latin America which his visit had convinced him was a rich source of literature very pertinent to the situation existing in other developing countries. The same applied to some extent to the South-East Asia Region where language was not a barrier to making use of that source of information. Publications produced by headquarters should, visibly and in fact, reflect the global character of WHO. In the absence of figures for 1984 and 1985 it was difficult to know whether the publications were reaching a wider audience. However, by their quality and diversity, the headquarters publications on the whole were worth every franc budgeted for them. His delegation also considered that it would be useful if articles were published from time to time in one journal or another on proven contributions of some traditional drugs to the curing of certain diseases.

Finally, he wished to congratulate the Organization on the early dispatch to the African countries of the documents for the current Health Assembly, thus demonstrating that WHO had taken good note of the replies from Member countries to its questionnaire. He hoped the practice would continue in the future.

Dr TRAORE (Mali) welcomed the opportunity thus provided to discuss health information support (programme 14) in Committee A. His delegation attached great importance to the programme because the wide dissemination of health information not only contributed to exchange of experience but also provided health workers in the field with very useful information which facilitated the correct performance of their work.

His delegation greatly appreciated the high quality of WHO publications but, because of limited financial resources, his country, like others, was having difficulties in connection with their proper use and wide dissemination within the country. It was financially impossible to provide each doctor in the rural areas and the central health administration with a suitable range of WHO publications. In order to overcome that handicap, the Ministry of Public Health and Social Affairs, in collaboration with the National School of Medicine and Pharmacy, was considering the preparation of a liaison bulletin containing not only national health information but also information on the developments in international health policy based on the various publications of the Organization.

His delegation was also glad to see, from paragraphs 2 and 4 of the statement for programme 14, that WHO would continue to increase its technical cooperation in the development and implementation of national policies and programmes in the field of health information support, and that regional offices, in addition to their support in the assessment of national needs and in the development of national policies in that field, would participate in the preparation and implementation of national health information programmes (paragraph 4). It was with some surprise therefore that his delegation had noted the absence of budgetary appropriations for country activities in the African Region and a reduction of the allocations for intercountry and regional activities at a time when the countries of the Region had an urgent need for resources with which to develop their health information systems. He hoped that an explanation would be forthcoming upon that point.

Dr RAMAROSON (Madagascar), expressing his delegation's support for programme 14, stressed the importance of valid health information for middle-level health personnel and primary health care workers. In the present economic context the difficulties experienced in obtaining access to the various international scientific publications and medical data banks were such that WHO publications often constituted the only means whereby the medical knowledge of health personnel could be updated. Consequently, his delegation supported all measures designed to improve the dissemination of WHO publications. The primary health care strategy for attaining health for all required that the orientation of activities and decision-taking should be thoroughly decentralized so that health work was effectively in harmony with community needs. That approach required, in addition to wide dissemination of information, adequate training of those responsible at the intermediate level, so that they could make optimum use of the information supplied by WHO in its publications, as well as of that provided by primary health care workers in their periodic reports. Furthermore, the establishment of an information feedback system for primary health care workers, which would be the responsibility of the middle-level workers, should help to improve motivation in the regular collection of basic data.

His delegation fully agreed with the Director-General that there was a need to constitute a critical mass of health-for-all leaders, and hoped that they would help to strengthen national managerial capacities by subsequently training health personnel at all levels to utilize the information supplied. The Director-General was to be congratulated on the high quality of the documentation issued in connection with the programme budget for 1986-1987.

Dr BATCHVAROVA (Bulgaria) said that without WHO's scientific, technical, administrative and other information it would be very difficult to attain the goal of health for all. Moreover appropriate information was an essential prerequisite in the implementation of the many programmes which the Committee had been discussing in recent days. Programme 14 seemed to be of rather modest proportions in the light of the high priority which Member States attached to the provision of information. Paragraph 11 of the programme statement, which reflected WHO's role in the establishment of national documentation centres for the purpose of making optimum use of the Organization's resources, was extremely important. It might be necessary to make a preliminary study of countries' requirements in order to determine the extent of the work to be done, for which much stronger financial support at the country level would be required. Recourse might perhaps be had to extrabudgetary funding.

Dr KYELEM (Burkina Faso) recalled that, when the Committee had considered programme 7 (Research promotion and development), his delegation had emphasized the importance of the transfer of know-how in the implementation of the health-for-all strategy. It was now surprised to note that the strong desire to support information activities at country level in the African Region and the Region of the Americas had not found expression in the budgetary provisions. His delegation therefore hoped that the Director-General would take the necessary action to ensure that national health information programmes in those two regions received all the support they needed.
Mrs GREWAL (India) said that her delegation welcomed the activities proposed under programme 14, particularly the emphasis that WHO intended to give to economical, high quality language services. Some of WHO's publications having a large circulation, such as World Health, would be more effective if world health information could be interpreted to a much wider audience; that the later revision of the programme statement might give some larger number of countries access to such an information service.

Her delegation shared the concern expressed by some members of the Executive Board at its seventy-fifth session regarding the long delay - sometimes up to 18 months - which occurred between the conclusion of technical meetings and the transmission of the relevant reports to Member States. Such delays should be reduced as far as possible.

Professor COLOMBINI (Italy) congratulated the Director-General on the high quality of the WHO publications issued by headquarters and by the Regional Office for Europe. World Health Forum and some of the technical reports were translated into Italian in his country.

Dr GUZMAN VELIZ (Chile) said that in the Region of the Americas there were some very good publications which, being issued in Spanish, could be read by Latin American health workers. In Chile the system whereby the price of each PAHO publication was reduced by 50% when it was purchased by the Ministry of Public Health had yielded good results; copies were widely distributed and health workers made substantial use of them. That served to emphasize the importance which the Government attached to the health information support programme for its health personnel.

Dr MONEKOSSO (Regional Director for Africa), replying to the delegate of Mali, explained that there was no allocation at the country level in the African Region because no country had requested such an allocation at the time when the budget proposals had been prepared. The decrease of approximately 2% at the intercountry level was due to a change in perceived priorities. Nevertheless, impetus was being given to health and biomedical information in the restructuring of WHO's activities in the African Region. The delegate of Mali might not yet have been informed that the library of the medical school at Bamako was in the process of being strengthened with the assistance of the Regional Office. In addition, countries were being encouraged to arrange for the appointment of health information officers to be responsible for disseminating information received from WHO within their country and for feeding information to WHO for subsequent distribution to other countries. The scheme was a new development which would obviously require an appropriate budgetary adjustment. Further information on the responses of Member States in the African Region would be provided at a later date.

Dr COOPER (Director, Health and Biomedical Information Programme) assured the Committee that the many valuable comments made with regard to specific publications would be taken into account.

Replying in particular to the delegate of Cameroon, he explained that, although the World Health Statistics Quarterly was produced through the health information support programme, the latter was not entirely responsible for it because the content was supplied by the programme on health situation and trend assessment. The publication had formerly been addressed to statisticians, epidemiologists and other professionals, but over the past two years efforts had been made to reorient it to respond to the information requirements of a much wider audience; those efforts would be continued with a view to providing properly analysed and interpreted quantitative information relating to the major health problems of the world.

He had been interested to learn that Mali was proposing to establish a national bulletin of health information. The Organization would be glad to supply any advice or assistance that might be required.

The delegate of Bulgaria had referred to paragraph 11 of the programme statement, concerning health literature services. Those services were, in fact, a most important component of the programme. They had to be flexible, and they had to be determined in the light of the priorities established for each region and country. The aim was to help to develop and strengthen the services and to establish regional networks in which resources were shared; optimum use was not being made of many available resources but, by the proper arrangement of networks, such resources could be shared for the benefit of a larger number. The programme was also trying to promote the transfer of recorded information, to improve the related manpower resources by means of fellowships, short courses and continuing education courses, and to provide back-up and reference services, such as bibliographical searches and photocopies. In that connection assistance was being received from a number of sources: for example, Italy was providing bibliographical information searches for countries in the
African Region, while Australia was providing information searches for countries in the Western Pacific Region, and the Karolinska Institute in Sweden was providing searches and photocopies for countries in the South-East Asia Region.

The Secretariat was well aware that the programme needed to be kept under constant review if it was to meet current needs. Dr Borgoffo had referred to the establishment of an expert advisory panel which would, in the long term, supply useful information regarding the impact of WHO publications and documents at the country level and help to determine the information needs of individual countries.

In the short term an intensive study was being made of publications policies at headquarters and in the regional offices, using expertise from both inside and outside the Organization. The purpose of the study was to find out how best to support Member States in their health-for-all strategies, to ascertain their specific needs, and to stimulate the development or improvement of their publishing policies or capabilities, as well as to define more accurately the target audiences for WHO publications and to arrive at a better method of establishing priorities in publishing. Also under consideration were ways of improving the control and selection mechanisms for publications and the criteria for deciding whether texts should be issued as global or as regional publications; ways of establishing a correct balance between global and regional publications and of adapting the language, presentation and illustration of publications to their target audiences; ways of utilizing the latest methods in the production of publications and of determining the extent to which the Organization should publish more in cooperation with other organizations and publishers; and ways of promoting the translation of WHO publications into additional languages and of adapting them to local conditions. Distribution, sales and promotion policies were also being investigated. The study should be completed by the end of 1985, and it was hoped that the programme would be in good shape for the 1986-1987 biennium.

Support services (programme 15)

Mrs GREWAL (India), speaking on programme 15 (Support services), welcomed the assurance given in paragraph 3 of the programme statement that output would be increased without additional human and financial resources by streamlining operations and making greater use of computer technology. Increased efficiency in the support services sector would release more funds for health programmes.

The DEPUTY DIRECTOR-GENERAL expressed thanks to the Committee for its active contribution to the work of the Health Assembly; the valuable points raised by delegates showed how seriously they took the Organization's work. Member States had demonstrated their determination to eradicate poverty and ill-health, despite the variety of cultures, ideologies and social and economic conditions.

FINANCIAL POLICY MATTERS: Item 22.3 of the Agenda (Documents PB/86-87; EB75/1985/REC/1, Part II, Chapter III, paragraphs 82-100; A38/27 and A38/INFO.DOC.12)

The CHAIRMAN drew attention to the following draft Appropriation Resolution, which superseded that recommended by the Board in its resolution EB75.R6; it took account of the Director-General's proposals and the recommendations of Committee B to the present Committee:

The Thirty-eighth World Health Assembly

RESOLVES to appropriate for the financial period 1986-1987 an amount of US$ 605 327 400 as follows:

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1 See document WHA38/1985/REC/2.
A. Appropriation section | Purpose of appropriation | Amount US $
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1. | Direction, coordination and management | 62 812 700
2. | Health system infrastructure | 179 084 500
3. | Health science and technology: health promotion and care | 101 123 300
4. | Health science and technology: disease prevention and control | 84 480 400
5. | Programme support | 115 799 100

Total Effective working budget | 543 300 000

6. | Transfer to Tax Equalization Fund | 52 000 000
7. | Undistributed reserve | 10 027 400

Total | 605 327 400

B. Amounts not exceeding the appropriations voted under paragraph A shall be available for the payment of obligations incurred during the financial period 1 January 1986 - 31 December 1987 in accordance with the provisions of the Financial Regulations. Notwithstanding the provisions of the present paragraph, the Director-General shall limit the obligations to be incurred during the financial period 1986-1987 to sections 1-6.

C. Notwithstanding the provisions of Financial Regulation 4.5, the Director-General is authorized to make transfers between those appropriation sections that constitute the effective working budget up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made, this percentage being established in respect of section 1 exclusive of the provision made for the Director-General's and Regional Directors' Development Programme (US$ 10 334 000). The Director-General is also authorized to apply amounts not exceeding the provision for the Director-General's and Regional Directors' Development Programme to those sections of the effective working budget under which the programme expenditure will be incurred. All such transfers shall be reported in the financial report for the financial period 1986-1987. Any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.5.

D. The appropriations voted under paragraph A shall be financed by assessments on Members after deduction of the following:

US $

(i) reimbursement of programme support costs by the United Nations Development Programme in the estimated amount of | 5 000 000
(ii) casual income in the amount of | 56 790 000

Thus resulting in assessments on Members of US$ 543 537 400. In establishing the amounts of contributions to be paid by individual Members, their assessments shall be reduced further by the amount standing to their credit in the Tax Equalization Fund, except that the credits of those Members that require staff members of WHO to pay taxes on their WHO emoluments shall be reduced by the estimated amounts of such tax reimbursements to be made by the Organization.

Professor ROUX (representative of the Executive Board) said that at its January session the Executive Board did not have definitive financial data at its disposal. It therefore established a Committee to Consider Certain Financial Matters prior to the Thirty-eighth World Health Assembly; that Committee had met on 6 May 1985. Committee B had then discussed
the subject, and its report to Committee A was contained in document A38/27.1 His remarks would take into account the deliberations of the Board, its Committee, and Committee B.

In its review of the proposed programme budget for 1986–1987 the Board had paid particular attention to the planned allocation of resources and the changes in the effective working budget as compared with that for the current biennium. The Board's review, reflected in paragraphs 86–100 of its report (document EB75/1985/REC/1, Part II), addressed a number of important budgetary and financial policy matters, although the figures contained in it were now somewhat outdated in view of the subsequent recommendations of Committee B. The Board considered that the effective working budget level of US$ 554 000 000, proposed by the Director-General, struck an appropriate balance between the need to advance towards the goal of health for all and the need for realism in view of the world economic situation. The proposed programme budget allowed for zero real growth in budgetary terms, but provided for a real increase of 4.2% at country level, achieved by means of corresponding real decreases at intercountry, regional, interregional and global levels. The effective working budget proposed by the Director-General and endorsed by the Executive Board represented an increase of 6.52% over the approved appropriations for the financial year 1984–1985.

The Board had noted with satisfaction, in paragraph 92 of the report, that there would be a review prior to the Health Assembly of the budgetary rates of exchange in respect of the major regional office currencies. The review, which had taken into account currency exchange developments up to the end of April 1985, had been carried out by the above-mentioned Committee of the Board, and by Committee B. On the basis of its review, Committee B had recommended that exchange rates between the US dollar and four of the major regional office currencies should be adjusted as proposed by the Director-General. The adjustments reduced the level of the proposed effective working budget for 1986–1987 by the sum of US$ 7 500 000.

The Committee of the Board and Committee B had also recommended that, because of the postponement in December 1984 by the United Nations General Assembly of an increase of one class of post adjustment, budgetary provisions relating to post adjustments for 1986–1987 should be reduced by US$ 3 200 000.

The combined effect of the two adjustments would be to reduce the total amount of the effective working budget for 1986–1987 from US$ 554 000 000 to US$ 543 300 000, an increase of US$ 23 200 000 (4.46%) over the approved programme budget for 1984–1985. Cost increases of 12.04% would be partly offset by decreases of 7.58% due to revised budgetary exchange rates.

As the final figure for casual income available as at 31 December 1984 had not been known at the time of the seventy-fifth session of the Executive Board, it had been agreed that the amount of casual income to be incorporated into the 1986–1987 budget would be reviewed by the Committee of the Board. The Committee recommended that US$ 56 790 000 of available casual income should be used for the 1986–1987 budget. Consequently, the increase in contributions by Member States to the effective working budget would be only US$ 20 910 000 (4.54%).

The draft Appropriation Resolution now before the Committee reflected all the adjustments to the proposed programme budget for 1986–1987 recommended by Committee B, the Board and its Committee.

Professor LAFONTAINE (Belgium) expressed satisfaction at Professor Roux's comments and endorsed the suggestions which had been made. He reserved the right to speak again but on another subject towards the end of the meeting.

Mr PALSSON (Iceland), speaking on behalf of the five Nordic countries, namely Denmark, Finland, Norway, Sweden and his own country, said that he sympathized with all efforts to make savings where possible provided that regional or country programmes were safeguarded. In the light of the thorough review by the Executive Board at its session in January of the current year and the clear and concise introduction to the debate in Committee A, he endorsed the proposed programme budget on behalf of those countries.

The right programme priorities had been set, although zero growth did impose a number of constraints. He was concerned, therefore, that the needs of developing countries would not be fully met and that some of the programmes would be too heavily dependent on extrabudgetary funding.

The delegations of the Nordic countries endorsed the recommendations made by Committee B regarding further ways of achieving savings and the proposal to apply casual income available as of 31 December 1984 towards reducing Member States' contributions. They also supported the proposed budgetary exchange rates and recommended that the draft Appropriation Resolution should be approved.

1 See document WHA38/1985/REC/2.
Dr SAVEL'EV (Union of Soviet Socialist Republics) said that once again the Director-General had recommended the approval of a proposed programme budget based on zero real growth, thus reflecting the need to stabilize the budget and the scope of the Organization's activities. However, the budget as a whole continued to increase, as did the level of Member States' contributions and the number of Member States in arrears in paying them. His delegation had repeatedly pointed out the need to stabilize both the budget and Member States' contributions in view of the considerable amount of extrabudgetary funds available. Accordingly, as in previous years, his delegation would abstain from the vote on the draft Appropriation Resolution.

Mrs GREWAL (India) said that, while supporting the draft Appropriation Resolution, her delegation was concerned that the proposed programme budget did not provide for any growth in real terms. It was opposed to the zero growth budgetary policy because the agreed targets and objectives of the Global Strategy for Health for All by the Year 2000 could not be attained if activities were limited by a predetermined level of resources. Of course, every effort should be made to improve efficiency and eliminate waste, but there was a limit to what could possibly be done in that direction.

During the discussions on the proposed programme budget, a great many requests for funding had been made by an increasing number of countries, not only for the strengthening of existing programmes but also for new programmes in areas which were only just being identified. It was not possible to choose between priorities in the war against disease, which had to be waged on all fronts, whether against infectious diseases, cancer or smoking.

A resolution had been adopted, calling for increased expenditure on health in national budgets. That approach should be extended to WHO, which should be provided with the budgetary resources it needed to help to implement the Global Strategy for Health for All by the year 2000, which was only 15 years away.

The difficult world economic situation and other short-term economic factors did not justify sacrificing agreed long-term targets. While it was true that a great many developing countries were unable to pay their assessed contributions, such countries were net beneficiaries of WHO activities and it was therefore in their interests to call for an increase in real terms in WHO's budget.

Although her delegation regretted that the budget proposals for 1986-1987 did not provide for any growth in real terms, it wished to congratulate the Director-General and his staff for making greater resources available at country level. It urged that, in the programme budgets for 1988-1989 and subsequent bienniums, provision should be made for an increase in resources in real terms in the light of the needs of Member States and the Global Strategy for Health for All by the Year 2000.

Dr SIMAO (Mozambique) expressed his delegation's satisfaction at the 4.2% increase in the proposed budgetary allocations for country activities, in spite of zero growth in the programme budget as a whole. That was a welcome trend, especially as far as African countries were concerned, as it would increase the ability of every country to develop its own national strategy to achieve the common goal of health for all by the year 2000. It was both possible and necessary to make further efforts to strengthen country programmes, in accordance with resolutions WHA29.48 and WHA33.17. WHO should support the efforts made by countries to implement their national strategies. His delegation believed that the time had come to take the appropriate measures to make the most efficient possible use of the resources available to WHO. He therefore noted with satisfaction the proposed reduction of some US$ 7 million in budgetary appropriations at global, interregional, regional and intercountry levels.

The decision to reduce intercountry programmes should be given full effect and every intercountry programme should be thoroughly analysed; only those programmes which seemed worthwhile should be initiated or continued.

The proposed budget for the Regional Office for Africa provided for an increase of 23% for the 1986-1987 biennium, made possible partly as a result of the reduction in budgetary appropriations for intercountry programmes. Noting that the proposed increase was to be used for personnel, management and general services, finance and equipment, he said that resolution WHA29.48 should be carefully applied to the African Region so as to ensure that both the best use of staff and the greatest possible savings in staff and management costs were made in order to strengthen field activities at country level. That was the most efficient way of using available resources.

Mr BOYER (United States of America) expressed appreciation of the informative documentation before the Committee, including the presentation of the budget proposals and financing arrangements and the tables showing how resources were distributed between regions and between major programmes.
He welcomed the saving of US$ 10.7 million made possible by the recalculation of the exchange rates in four regional offices and the postponement of one class of post adjustment. That saving would make it possible to decrease the assessed contributions from Member States. In view of the difficulties faced by many States in paying their assessments, he hoped that the Director-General and his staff would continue to seek out other ways to reduce the cost to Member States whilst protecting the programme activities of WHO.

The United States delegation welcomed the recommendation from Committee B that a larger amount of casual income be used to help finance the budget. Such a recommendation, it believed, reaffirmed the principle, established two years previously, that the Health Assembly should apply to the budget all the casual income available at the end of the year preceding its adoption. It further believed that another principle should be firmly established - namely that all the gains resulting from exchange rate fluctuations should be credited to casual income; it was not deemed proper for Regional Directors to be allowed to use 10% of exchange rate gains without further decision by any governing body. If all exchange rates were credited to casual income, the governing bodies could give appropriate consideration to the use of that money.

More importantly, the United States delegation was pleased that the Director-General had been able to cope effectively with pressures from opposite directions; by holding the overall budget to zero real growth and by shifting resources within the budget to provide about 4% growth in country programmes, he had been able to please everybody.

As his delegation had already stated, it felt some concern about the way in which the components of cost increases were calculated and presented; it hoped that the Director-General and his staff would keep that matter under constant review.

His delegation also hoped that more attention would be paid to the managerial strategies of implementing national programmes when the forthcoming programme budget, especially at the regional and country levels, was being prepared. The Director-General had made it clear on several occasions that improved management of internal resources by Member States and improved ability to absorb and effectively use external resources would enable sizeable amounts of new funds from external sources to be located to help advance the objectives of health for all. But countries must be prepared to make better use of WHO resources and to make new commitments of their own in the reallocation of national resources and programmes. For that reason, the United States believed that the new regional programme budget policy statements and other steps proposed by the Director-General, including the review of individual country programmes by regional committees, would permit better use of resources.

It was noted with regret that the current Health Assembly had failed, as had its predecessors, to focus on the relative allocation of money between and among programmes. Committee A had spent almost two weeks looking at individual programmes, but had never taken an overview of the relative distribution of money. Perhaps one particular programme might be allocated too much or too little money in relation to others. Some programmes might be marginal and could perhaps be dropped in favour of more important ones. Of course, there was bound to be resistance to changes, but he hoped that the Director-General and his staff and the Executive Board would encourage the Health Assembly to address the allocation of resources among programmes rather than simply the content of each individual programme in isolation, however useful that exercise might be.

Those were, however, matters for the future, and he wished to say that the United States delegation was pleased with the proposals put before the Committee, and more particularly so with the philosophy expressed in the Director-General's introduction to the proposed programme budget and the conservative and careful approaches to the financing. For those reasons, his country would vote in favour of adoption of the Appropriation Resolution as proposed, hoping that the decision of the Health Assembly would be unanimous.

Professor SENAULT (France) said that his delegation had already had the opportunity to express its satisfaction with the Director-General's concern to produce a strictly worked out budget. He was pleased to state that, after listening attentively to the account by the representative of the Executive Board of that body's deliberation on the matter, and noting the recommendations by Committee B, his delegation would vote in favour of the draft Appropriation Resolution before the Committee.

Dr REID (United Kingdom of Great Britain and Northern Ireland) recalled that his delegation, at the beginning of the debate on the programme budget, had expressed its general agreement with the Director-General's proposals. It had welcomed the real increase in expenditure at country level, as well as the Director-General's realism in achieving that result within a budget based on zero growth, also in real terms.

Since then, his delegation had been gratified by the adoption of the resolution on programme budget policies and looked forward to its implementation. He was glad that the
Director-General had been able to suggest appropriate adjustments in the exchange rate between the United States dollar and four of the major regional office currencies, with consequential savings. Accordingly, his delegation supported the proposals contained in the report of Committee B to Committee A on that point, as well as the proposed use of some US$ 57 million of available casual income towards the financing of the budget for 1986-1987. His delegation also supported the proposed Appropriation Resolution.

Dr KLIVAROVA (Czechoslovakia) said that her delegation very much valued the work of the Director-General and his staff in preparing the budget with a zero increase in real terms; nevertheless, and as a result of currency fluctuations, there would be an increase of 4.9% in Members' contributions. Consequently, her delegation would abstain from the vote on the proposed Appropriation Resolution.

Dr BRÄMER (German Democratic Republic) said that his Government's views had not changed: its basic premise was a long-term stabilization of WHO's budget. If the coordinating function of WHO were emphasized and increasing efforts of Member countries were taken into account, the aim should even be a slight reduction of the budget. In view of the present situation of financial constraint, his delegation was not authorized to adopt a budget showing a nominal increase as compared with 1984-1985. However, the high professional standard of the programme proposal itself and the efforts that had obviously been made to increase appropriateness and effectiveness, together with the desire to pay tribute to humanitarian aims, would make it easier for his delegation not to vote against the proposal.

As in previous years, his delegation would stress that the German Democratic Republic had not contributed to growing inflation rates, and therefore wished not to share in the additional burden deriving from them. However, he assured the Committee that his country would continue to support programme implementation at all levels.

Dr ADANDE-MENEST (Gabon) expressed his delegation's support for the proposed Appropriation Resolution. He did not need to enlarge on the reasons for that support; many delegations had already clearly indicated how logical and constructive the budget was in the light of the resources available. His delegation wished to reiterate its congratulations and encouragement to the Organization, which, despite all the problems due to currency fluctuations, was still leading the way towards health for all by the year 2000.

The CHAIRMAN put to the vote the draft Appropriation Resolution.

The draft Appropriation Resolution was approved by 88 votes to none, with 7 abstentions.1

The DIRECTOR-GENERAL thanked the delegates on behalf of themselves for what he considered to be a vote of confidence in their own policy, which they had adopted nine years previously in resolution WHA29.48 and which their Organization had been trying consistently to follow ever since. That policy was to increase investments and activities in countries, especially developing countries, no matter how restrictive the total budgetary ceiling was and, at the same time, to make sure that the Organization's resources were wisely invested and properly used in countries.

He also considered the Committee's vote to be an expression of its renewed faith in the potential for their and all people's development throughout the world, and in the highly important role that the strategy for health for all by the year 2000 played in ensuring that kind of human development really did take place and take root.

In that same vein of enlightened self-support he welcomed on the Committee's behalf its endorsement of the introduction of regional programme budget policies. The sole purpose of those policies was to help the Member countries to squeeze the absolute maximum out of their limited collective resources in order to carry out faithfully their collective policies, so assiduously defined in the present and previous Health Assemblies. He referred to his concluding statement in the Introduction to the proposed programme budget: it was not a matter of tightening the belt, but rather of making sure that it fitted accurately with no unnecessary slack.

It would now depend on delegates and their colleagues who represented their countries in the regional committees to make sure that those policies were clearly formulated and faithfully carried out in their own countries as well as through intercountry and regional

1 Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA38.32.
activities. That would require a highly democratic interaction, with all the undoubted advantages of democratic endeavours, but also with the discipline it imposed on all Members. The democracy which existed in WHO would not be possible without a corresponding discipline.

If optimal use were to be made of all the resources which the Organization could muster for health, and in particular for its strategies for health for all by the year 2000, a greater effort would have to be made to understand what WHO could do and what it could not do. He and his colleagues the Regional Directors, and indeed the whole staff, would have to try much harder to help the countries understand what WHO's policies were really all about; but the countries also would have to make no less an effort to understand. The Organization would also have to do everything in its power to make sure that its resources remained at least at their present level, not to speak of increasing resources for health, on which the Member States had adopted a resolution at the present Health Assembly.

He assured the Committee that the two matters — understanding what could and could not be done, and maintaining resources for health at least at the present level — were closely linked. He was personally convinced that, in order to ensure that governments of Member States, of which ministries of health were only one part, continued to provide at least the current level of resources for health, WHO would have to maintain its credibility and integrity as a health organization. WHO's was the only sector that had dared to seek a consensus on a worldwide policy as well as on a well-defined worldwide strategy for giving effect to that policy. He thought that it had succeeded rather well.

To maintain its credibility and uphold its integrity, the Organization would have to demonstrate unequivocally that it was wholly dedicated to a health policy which, if carried out with unswerving determination, would undoubtedly have a profound and highly positive lasting effect on genuine social and economic development throughout the world. He repeated that supporting Member States in carrying out WHO's daring health policy was what the Organization could do. What it could not do was to define foreign policy, by which he meant policy that was foreign to its constitutional mandate as a specialized health agency of the United Nations system.

In his opening address to the Health Assembly, he had made a plea for a return to mature faith in human development. He would end by making a further plea for mature faith, this time in the ability of WHO to fulfill its health mission and thereby make a very solid contribution indeed to that development.

3. FIFTH REPORT OF COMMITTEE A (Document A38/38)

Mr RUBIO (Peru), Rapporteur, read out the draft fifth report of Committee A.

The report was adopted (see document WHA38/1985/REC/2).

4. CLOSURE

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

The meeting rose at 11h45.
COMMITTEE B
FIRST MEETING
Tuesday, 7 May 1985, at 14h30
Chairman: Mr R. ROCHON (Canada)

1. ELECTION OF VICE-CHAIRMEN AND RAPPORTEUR: Item 23 of the Agenda (Document A38/22)

The CHAIRMAN expressed gratitude for his election and welcomed those present, in particular the delegates of the new Members of the Organization, Brunei Darussalam and Saint Christopher and Nevis.

He drew attention to the third report of the Committee on Nominations (document A38/22) in which Dr B. P. Kean (Australia) and Dr M. M. Pal (Pakistan) were nominated for the offices of Vice-Chairmen of Committee B, and Dr Zsuzsanna Jakab (Hungary) for that of Rapporteur.

Decision: Committee B elected Dr B. P. Kean (Australia) and Dr M. M. Pal (Pakistan) as Vice-Chairmen and Dr Zsuzsanna Jakab (Hungary) as Rapporteur.

2. ORGANIZATION OF WORK

The CHAIRMAN, pointing out that the Health Assembly's schedule was a heavy one, urged members to limit the length of their interventions in order 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 those of their respective governments.

He suggested that, in accordance with the Health Assembly's previous 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 by the Health Assembly concerning its 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 the first Saturday, while the Technical Discussions were being concluded. Committee B would meet on Wednesday and Thursday afternoon of the current week but not on Friday or Saturday. It 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.

3. REVIEW OF THE FINANCIAL POSITION OF THE ORGANIZATION: Item 24 of the Agenda (Document A38/5)

Mr FURTH (Assistant Director-General), introducing the item, drew the attention of delegates to the interim financial report of WHO for the year 1984 (the first year of the two-year financial period), which was contained in document A38/5. A final financial report covering the full biennium 1984-1985 would be prepared at the end of the second year of the financial period for submission to the Health Assembly in 1986. The interim financial report was similar in contents and presentation to the financial report presented two years previously. It contained a certain number of key financial data, and, in textual form in the Introduction on pages 5 to 7, the most significant financial developments that had occurred in 1984. It also contained an Appendix listing the extrabudgetary resources available for programme activities during the year 1984 in considerable detail, in particular
in respect of the Voluntary Fund for Health Promotion. For each donation it gave the funds contributed, the amount obligated and the balance available at the end of 1984. That degree of detail met the need of a number of donors to the Voluntary Fund for Health Promotion and thus obviated individual reporting by WHO to such donors. The Appendix also included a number of summaries, notably a summary on page 25 of income and expenditure during 1984 under all extrabudgetary funds. On pages 26-34 were shown cumulative figures of all donations by donor both to the Voluntary Fund for Health Promotion and to other WHO funds.

Consideration of the substantive contents of the interim report called only for brief reference to two significant developments described more fully in the Introduction and backed up by the relevant tables of the report. The first concerned the collection of assessed contributions. Although the rate of collection of assessed contributions as of 31 December had been only slightly lower in 1984 than in 1983 (93.88% as compared to 94.92%), the number of Member States which at year-end had not paid any part of their current year's contribution had continued to increase. As indicated in paragraph 3 of the Introduction, on page 5, at the end of 1980 only 11 Members had not paid any part of their current year's contribution; that number had increased to 27 at the end of 1981, to 42 at the end of 1982, to 45 at the end of 1983, and finally to 49 at the end of 1984. That disturbing trend was a cause of serious concern to the Director-General, who could do little more than to appeal to Members to pay their contributions in the full amount and on time. The second, and happier, development was the very large amount of casual income that had become available as at 31 December 1984: US$ 56,791,706. That unprecedented amount (at the end of 1982 it was only slightly lower, by some US$ 500,000) was largely due to two factors: first, continuing high interest rates in 1983 and 1984 on WHO's bank deposits, which averaged 9.31% in 1983 and 10.05% in 1984, and, secondly, a very large budgetary surplus for 1982-1983 resulting primarily from favourable exchange rate developments during that period. As reported in the Financial Report presented to the World Health Assembly in 1984, the 1982-1983 budget surplus had amounted to US$ 15.5 million, of which US$ 12.1 million had been due to favourable rates of exchange. That budgetary surplus in 1982-1983 had been credited to casual income in 1984 only to the extent that arrears in contributions for that financial period had been collected in 1984. Unfortunately, as was shown on the second line in Table 6 on page 19 of document A38/5, only about US$ 7.1 million in arrears of contributions out of a total of US$ 14.3 million had been received in 1984. Nevertheless, the Director-General and the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-eighth World Health Assembly had been able to recommend that virtually all the casual income available at year-end 1984, namely US$ 56.7 million, should be used to help finance the proposed 1986-1987 budget. Committee B would be considering the matter under item 24.4 of the agenda.

As the accounting rates of exchange of the US dollar in relation to the Swiss franc had hitherto been equal to or higher than the WHO budgetary rate of exchange for the present biennium, and as the average accounting rates of exchange of the US dollar in relation to the major regional office currencies had hitherto been more than 10% higher than the budgetary rates of exchange of such currencies, it could safely be predicted that there would again be a budgetary surplus at the end of the present biennium, that is, at the end of 1985. Because of those developments, and even though interest earnings were likely to be less important in the next biennium due to somewhat lower interest rates, it was possible that the amount of casual income available at the end of 1986 to help finance the budget for 1988-1989 might be as high as the US$ 56.7 million now being proposed to help finance the budget for 1986-1987. It was important to bear that factor in mind, since a decline in the amount of casual income to be appropriated for the 1988-1989 budget as compared to the amount appropriated for 1986-1987 would result in a corresponding increase in assessments of Member States, even if the level of the budget should remain the same from one financial period to the next.

The interim financial report, pursuant to arrangements approved by the Health Assembly in 1980, was not accompanied by a certificate from the External Auditor, nor was there a separate report from the External Auditor. It should, however, be pointed out that had the External Auditor felt the need for a separate report, he would have been free to present one. The financial operations of WHO were of course subject to continuous review by both internal and external auditors, and, in accordance with the approved arrangements, the External Auditor was expected to certify the final financial statements for the biennium 1984-1985 when they were issued in 1986. At that time the External Auditor would also probably present a report commenting upon the financial management of WHO for the two-year period 1984-1985.
Interim financial report on the accounts of WHO for 1984 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 EB75/1985/REC/1, resolution EB75.R16, A38/5 and A38/23)

Mr GRIMSSON (representative of the Executive Board), introducing the sub-item, said that the first report of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Health Assembly (document A38/23) covered the review by the Committee, on behalf of the Board, of the Director-General's interim financial report for the year 1984. In line with biennial budgeting and financial reporting practices approved by the Health Assembly neither an audit certificate nor a report from the External Auditor were called for in respect of the interim financial report.

In the course of its review, the Committee had paid particular attention to the matters reflected in paragraphs 3, 4, 5, 6 and 7 of its report, namely delays in the receipt of assessed contributions, the amount of casual income at 31 December 1984, the rate of delivery of the regular budget in 1984, the apparent decline in available extrabudgetary resources, and the reason for extensive reporting under extrabudgetary resources, which served the needs of a large number of contributors regarding financial reporting on their contributions to WHO. 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 A38/23.

Dr SAVEL'EV (Union of Soviet Socialist Republics) noted that the interim financial report for the year 1984 showed that expenditure within the accounting period concerned had been in accordance with the programme budget already adopted, without the need for recourse to supplementary sources of finance. However, it was impossible to ignore the fact that the number of Member States in debt to the Organization was growing, and that at the close of 1984 nearly half of them were in that position while the record number of 49 had not paid anything for the year in question. That indicated that the payment of contributions, which were continually increasing in amount, was becoming an insupportable burden for many countries — in particular, for the developing countries — and that there was a need to stabilize WHO's budget. One way in which that could be achieved was to make the optimum use of WHO's resources, and to seek economies within the Organization not only at country and regional levels, but at all levels of WHO's activities. That would make it possible to limit the harmful effects of inflation without having to increase the budget.

Mr BOYER (United States of America) was pleased to note that the interim report reflected a financially healthy WHO, in regard both to voluntary programmes and the regular budget. However, he shared the concern expressed by previous speakers as to the slow rate of payment of assessed contributions. Whereas in 1980 only 11 countries had made no payment for the preceding year, in 1984 49 countries had paid nothing, amounting to nearly one-third of the total WHO membership. He agreed with the delegate of the USSR that that was an alarming trend, since it raised the serious question of how assessed contributions were to be met if the WHO budget continued to rise. Some thought should be given as to how the Organization could be operated more economically, and financing techniques should be sought which would limit the amount of increases in assessments on Member States.

He drew attention to the table on page 18 of the same report, which indicated that the balance of the casual income account at the end of December 1984 had stood at US$ 56 791 706. However, the figures given in the first and second paragraphs at the top of the same page gave the impression that, by 1 January 1985, only one day later, the account would contain as much as US$ 15 million more. He would appreciate clarification on that point, and would like to know what was the current balance of the casual income account.

Mr FURTH (Assistant Director-General), in reply to the delegate of the USSR, said that the Director-General was also greatly concerned about making the optimum use of available resources and seeking ways of making internal economies. In reply to the question raised by the United States delegate, he pointed out that the figure of more than US$ 7 million mentioned in the first paragraph on page 18 of the report represented monies due to the Organization, but not yet received, in respect of interest on deposits and securities. When that interest was actually paid in the course of the current year, a proportion of it — approximately 60% — would be credited to casual income, the remaining 40% being credited to other appropriate funds, including extrabudgetary funds.

The larger figure shown in the second paragraph on page 18 of the report reflected the fact that a budgetary surplus of some US$ 15 million had been incurred in respect of the financial period 1982-1983. Unfortunately, however, as shown in line 2 in the table on
page 19, only some US$ 7 million of arrears of contributions had been collected in 1984, and by 31 December of that year there was still about US$ 8 million outstanding.

He was not able to say at the present stage how the balance of the casual income account stood, since the distinction between casual income and interest earned on extrabudgetary funds had not been made for every fund and certain components of casual income were not calculated and recorded until the end of the year. However, he was fairly confident that, unless use had to be made of the casual income facility in 1986, and unless the rate of collection of contributions fell even lower than at present, there should be an amount of casual income available by the end of 1986 which would be at least equivalent to that available (US$ 56.7 million) as at 31 December 1984.

The draft resolution on the interim financial report was approved.1

Status of collection of assessed contributions and status of advances to the Working Capital Fund: Item 24.2 of the Agenda (Document A38/6)

Mr FURTH (Assistant Director-General), introducing the item, said that document A38/6 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 1985, total collections of 1985 contributions in respect of effective working budget represented 32.67% of the assessments on the Members concerned. That rate was very substantially lower than the rates achieved as of 30 April in 1983 and in 1984. Further, at 31 March 1985, only 10.21% of 1985 contributions had been collected, representing the lowest rate achieved since 1953, in fact the lowest rate in over 30 years.

It would be noted from the report that on 1 January 1985 total arrears of contributions due for years prior to 1985 from Members actively participating in the work of the Organization amounted to US$ 22 080 722. Although payments received up to 30 April 1985 had reduced such arrears to US$ 15 498 028, as many as 57 Members contributing to the effective working budget still owed contributions in respect of years prior to 1985. Of those 57 Members, 35 had made no payment at all in respect of the 1984 instalment, and thus owed that instalment in full.

During the first seven days of May, payments totalling US$ 703 475 had been received from six Members (Algeria, Botswana, Colombia, Democratic People's Republic of Korea, Israel and Kenya) in full or part settlement of their 1985 assessments, thus raising the percentage of current year contributions collected from 32.67% at 30 April 1985 to 32.97% at 7 May 1985. (On the same date the previous year the latter percentage had been 46.76%.) Furthermore, since 30 April 1985 payments totalling US$ 313 493 in respect of arrears of contributions had been received from eight Members (Central African Republic, Colombia, Democratic People's Republic of Korea, Dominican Republic, Guatemala, Kenya, Paraguay and Peru).

The Committee's attention was drawn to paragraph 5 of the report, which contained a text of a draft resolution for its consideration.

Professor SHERIF (Libyan Arab Jamahiriya) stated that before arriving in Geneva he had arranged for the payment of his country's contribution for 1984-1985.

Mr FURTH (Assistant Director-General) said that he was glad to learn that the contribution from the Libyan Arab Jamahiriya would soon be forthcoming, although there had as yet been no notification to the Organization that the deposit in WHO's account had been made.

Dr MAFIAMB (Cameroon) said that document A38/6 showed that Cameroon was in arrears in the payment of its contribution for 1985 and part of that for 1984. His delegation regretted that situation. His Government had, in fact, sent its contribution for 1984, but by the time it had arrived in New York the amount had been devalued as a result of the rising value of the United States dollar. On 26 April 1985, the Ministry of Finance in Yaoundé had taken urgent measures to send to the WHO account in the Federal Reserve Bank in New York the sum of 12 603 500 CFA francs which, at the rate of 475 CFA francs to the US dollar, should be more than sufficient to discharge his country's debts for 1984 and 1985.

Recalling that the Secretariat issued a regular monthly statement showing the status of collection of annual contributions and of advances to the Working Capital Fund, he said that difficulties in effecting payment of contributions sometimes arose because the number of the bank account to which payment should be made was not known, and suggested that each monthly statement indicate the WHO account number in the Federal Reserve Bank in New York to which payments should be made.

1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA38.2.
The CHAIRMAN said that the Secretariat would no doubt take that suggestion into consideration.

The draft resolution was approved.¹

Report on casual income, budgetary rates of exchange and other adjustments to the proposed programme budget for 1986-1987; Item 24.4 of the Agenda (Documents EB75/1985/REC/1, resolution EB75.R5, and A38/25²)

The CHAIRMAN noted that there were three separate issues to be considered. One concerned the amount of casual income that was to be used to help finance the budget for 1986-1987, one concerned the question of budgetary rates of exchange and savings relating to post adjustments in 1986-1987, and one was the question of the facility to be granted to the Director-General in 1986 and 1987 to use available casual income to help offset any adverse effects that might result from currency fluctuations in those years. He suggested that those three issues should be dealt with separately.

It was so agreed.

Amount of casual income to be used to help finance the budget for 1986-1987

Mr GRIMSSON (representative of the Executive Board), introducing the first of the three issues, said that the Executive Board had endorsed a proposal by the Director-General to appropriate the amount of US$ 56 560 000 of casual income available at 31 December 1984 to help finance the proposed programme budget for 1986-1987, and thus reduce the assessed contributions of Member States.

Since the final figure for casual income available at 31 December 1984 would not be known until the subsequent preparation of the interim financial report for that year, it had been agreed that the amount of casual income to be used to help finance the budget for 1986-1987 would be reviewed by the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-eighth World Health Assembly. That review had been made on 6 May. It had been noted that the total amount of casual income available at 31 December 1984 had been US$ 56 791 706 as compared to the estimated amount of US$ 56 560 000 reported to the Board in January, and accordingly the Director-General proposed that an additional amount of US$ 200 000 of available casual income be used to help finance the proposed programme budget for 1986-1987, thus raising the total amount to be used for that purpose to US$ 56 700 000. As mentioned in paragraph 2 of document A38/25, the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-eighth World Health Assembly had decided to recommend to the Health Assembly that it approve that proposal.

Dr BISKUP (Federal Republic of Germany) pointed out that only 60% of the income earned in 1984 was to be used to help finance the budget and thus reduce the contributions of Member States. A substantial sum had been earned in 1984 but had not yet been transferred to casual income. He therefore suggested that the sum concerned should also be appropriated to help finance the proposed programme budget for 1986-1987.

Mr BOYER (United States of America) said that, in view of the difficulties experienced by Member States in paying their assessed contributions, every effort should be made to appropriate as much casual income as possible in order to reduce such contributions. The original forecast contained in the budget document had been that US$ 56 500 000 of casual income would be available at the end of December 1984. That forecast, however, had been based on an estimate made in November 1984, while the actual amount available at the end of 1984 had been US$ 56 791 706. The Director-General had accordingly increased to US$ 56 700 000 the amount which he recommended should be appropriated from casual income to help finance the regular budget. That amount had presumably been arrived at by rounding off to the nearest US$ 100 000, whereas it might be better to have a figure rounded off to the nearest US$ 10 000. He therefore proposed that the Committee should recommend that

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA38.3.
² Document WHA38/1985/REC/1, Annex 1.
US$ 56 790 000, instead of US$ 56 700 000, should be appropriated to help finance the proposed programme budget for 1986-1987, i.e., an increase of US$ 90 000; that was a considerable sum, being equal to the entire annual assessed contributions of four Member States.

Dr HASEGAWA (Japan) and Dr SAVEL'EV (Union of Soviet Socialist Republics) supported the United States proposal.

Mr FURTH (Assistant Director-General), commenting on the suggestion by the delegate of the Federal Republic of Germany to the effect that additional casual income which had been earned on an accrual basis but which had not actually been received on 31 December 1984 should also be appropriated to help finance the proposed programme budget for 1986-1987, pointed out that the casual income account was operated on a cash and not on an accrual basis. Consequently, the 60% figure referred to was very approximate, and some of those funds might not yet have been received. The exact amounts of interest to be allocated to casual income and of interest to be allocated to the other funds were not yet known. Moreover, even if it were easy to make the suggested allocation at the present time, which was definitely not the case, a serious objection in principle would arise, since implementation of the suggestion would mean "robbing Peter to pay Paul". Casual income earned during two whole calendar years had consistently been made available to finance a programme budget for two years. If casual income which had been received in 1985 were now to be used to help finance the programme budget for 1986-1987, there would definitely be less casual income available for the following biennium 1988-1989, because casual income received during the two full calendar years 1985 and 1986 would not be wholly available to help finance the budget for 1988-1989. As a result Member States' assessed contributions would increase very sharply in the 1988-1989 biennium. That was hardly a desirable prospect.

Another alternative would be for the Director-General to make no proposal regarding the amount of casual income to be used to finance the programme budget when he presented his budgetary proposals in January of the odd-numbered years and to wait until the Health Assembly in May to notify Members States of the amount available at that time. Member States would derive no advantage from such a procedure. Casual income earned over a period of two years (e.g., from May 1985 to May 1987) would still be available for the biennial budget, but neither Member States nor members of the Executive Board would know ahead of time what the assessed contributions of Member States would be. Thus the suggestion made by the delegate of the Federal Republic of Germany, although well intentioned, would be difficult to implement in practice and the resulting situation would not be very helpful to Member States.

With regard to the United States' proposal, he said that the Director-General's proposals concerning available casual income had always been rounded off to the nearest US$ 100 000; he could however, see no objection to the appropriation of an additional US$ 90 000 in the present instance.

Dr BISKUP (Federal Republic of Germany) indicated that, in the light of Mr Furth's explanation, he would withdraw his suggestion.

Committee B adopted the United States' proposal to recommend to Committee A that an amount of US$ 56 790 000 should be appropriated from casual income to help finance the regular budget for 1986-1987.1

Budgetary exchange rates and other adjustments

Mr GRIIMSSON (representative of the Executive Board) said that at its meeting on 6 May 1985, the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-eighth World Health Assembly had reviewed - in the light of the discussions at the seventy-fifth session of the Executive Board in January 1985 - a report by the Director-General on possible adjustment of budgetary exchange rates in the light of currency exchange developments up to April 1985. The Director-General's report was attached to document A38/23.2

As regards the US dollar/Swiss franc budgetary exchange rate, the Committee of the Executive Board was in agreement with the Director-General's conclusions as set out in the second half of paragraph 2 of his report and with his recommendation that the budgetary rate

1 See the report of Committee B to Committee A (document WHA38/1985/REC/2).
2 Document WHA38/1985/REC/1, Annex 1, Appendix.
of exchange for the proposed programme budget for 1986-1987 should be maintained at 2.50 Swiss francs to one US dollar.

With regard to the budgetary rates of exchange for four major regional office currencies - namely the CFA franc, the Danish krone, the Indian rupee and the Philippine peso - the Committee of the Executive Board had noted that, as had been the case when the Board had met in January 1985, the differences between current rates of exchange and those originally used in the preparation of the relevant regional budget estimates remained significant enough to justify certain adjustments as set out in paragraph 5 of the Director-General's report. As a result of its review, a majority of the members of the Committee considered that a certain amount of additional protection against possible unfavourable exchange rate fluctuations over and above that proposed by the Director-General in respect of those four major regional office currencies was justified. The details of the adjustments in budgetary rates of exchange thus recommended by the Committee were set out on page 2 of document A38/25; it should be noted that the figures in respect of the accounting rate of exchange for May 1985 for the Danish krone and the Indian rupee had been inadvertently reversed. The adjustments would have the effect of reducing the level of the effective working budget for 1986-1987 by US$ 5.1 million.

At its meeting on 6 May 1985, the Committee of the Executive Board had also been informed that the decision of the United Nations General Assembly to delay an increase by one class of post adjustment for New York in December 1984 had had the effect of slowing down post adjustment changes at other duty stations. The Director-General therefore proposed to reduce the relevant budgetary provision for 1986-1987 by an estimated amount of US$ 3.2 million. That proposal had been endorsed by the Committee of the Executive Board.

Taken together, and if adopted, the recommendations by the Committee of the Executive Board would reduce the total amount of the proposed effective working budget for 1986-1987 from US$ 554 million to US$ 545.7 million, representing an increase over 1984-1985 of 4.92% and an increase in the assessments for the effective working budget of 5.08%.

Mr BOVER (United States of America) commended the Director-General on his proposal to make a saving of US$ 3.2 million in the context of the postponement by the United Nations General Assembly of an increase by one class of post adjustment in New York. WHO was likely to be the only organization in the United Nations system to volunteer to take such a courageous step, although a similar reduction might well be justified in the case of most other agencies.

As regards the recalculation of the exchange rates at four regional offices, it was quite clear that the exchange rates used when the proposed programme budget had originally been calculated were greatly out-of-date, as noted by the Executive Board at its seventy-fifth session. The Director-General had commendably offered to recalculate the portions of the proposed programme budget that related to the CFA franc, the Indian rupee, the Philippine peso and the Danish krone, in a manner that would result in a further reduction of US$ 7.5 million, but there appeared to be some disagreement between the Director-General and the Committee of the Executive Board concerning the amount by which the original exchange rates should be recalculated. The Director-General had proposed a margin of approximately 10% to protect programme activities in the event in a fall in the exchange value of the US dollar. For instance, in the case of the Danish krone, the Committee of the Executive Board was proposing an exchange rate of 9.50 to the dollar, offering a margin of protection of 15-20%, whereas the Director-General was proposing an exchange rate of 10 krone to the US dollar, with a margin of only 10%. In his view the Director-General's proposal provided adequate protection and deserved strong support.

With regard to the exchange rate to be used in relation to the Swiss franc and the US dollar, the proposed programme budget had been calculated at a rate of 2.50 francs to the dollar, whereas the rate was now almost 2.70 francs to the dollar. At an earlier session of the Health Assembly it had been agreed, in considering the proposed budget, that in the event of changes between the rate at the time when the proposed budget was prepared and that prevailing when the Health Assembly took place, the most recent rate would be used. He understood that the official United Nations exchange rate for May 1985 was 2.64 Swiss francs to the dollar and would therefore propose that the Director-General be requested to recalculate the portions of the proposed programme budget relating to the Swiss franc at that rate. Any risk that might be involved would be covered by the facility provided in the usual income account for the purpose of protecting programme activities in the event of a fall in the value of the dollar. He believed that such protection would in fact be provided even if the dollar fell as low as 2.20 Swiss francs.
Dr BISKUP (Federal Republic of Germany) concurred with the view that exchange rates should be realistic, and said he believed that a Swiss franc/US dollar exchange rate of 2.64 would indeed be realistic as far as the regular budget was concerned. Where the regional budgets were concerned, he would support the Director-General's proposals. Turnig to the draft resolution recommended in resolution EB75.R5, he submitted that WHO was not empowered "to earn casual income"; operative paragraph 5 of the recommended resolution was not in line with the Organization's financial regulations, and should therefore perhaps be deleted.

Dr HASEGAWA (Japan) supported the United States proposal regarding the Swiss franc/US dollar exchange rate.

Mrs GARCIA (Cuba) said that since the conditions prevailing on the international finance market did not permit the establishment of stable rates of exchange, it might be better for the Organization to maintain a Swiss franc/US dollar exchange rate of 2.50 as proposed by the Secretariat; that rate had, moreover, already been adopted by other international organizations.

Mr BROCHARD (France) did not share the concern expressed by some members of the Committee of the Executive Board that the adjustments proposed by the Director-General might expose the regional programmes to financial difficulties. The Organization was making laudable efforts to restrict the budget without affecting programmes, and those efforts should be encouraged.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) supported the views of the United States delegate regarding the proposed adjustment in WHO's budget resulting directly from the United Nations General Assembly decision to postpone an increase in the post adjustment. He also agreed with previous speakers that the Director-General's proposed budgetary rates of exchange for the regional budgets should be maintained.

Mr CHAMPENOIS (Belgium) supported a Swiss franc/US dollar exchange rate of 2.64. He also considered that the Committee should endorse the Director-General's proposals for the rates of exchange for the four regional offices.

Mr BALAKRISHNAN (India) said that his delegation had listened with interest to the views of some of the bigger contributors on the subject of the Swiss franc/US dollar exchange rate, but saw no good reason why the single, May 1985, rate of 2.64 should be adopted rather than an average rate taken over a longer term; after all, a two-year period was being planned for. It consequently favoured a rate of 2.50 Swiss francs to the US dollar. It also supported the view of the Committee of the Executive Board that the Indian rupee/US dollar rate should be set at 10.50 for the Regional Office for South-East Asia.

Dr SAVEL'EV (Union of Soviet Socialist Republics) supported the proposed Swiss franc/US dollar exchange rate of 2.64 for the regular budget, and the proposals of the Director-General concerning exchange rates for the regional offices.

Mr FURTH (Assistant Director-General), replying to points raised, said that, with regard to the four regional currencies, only the delegate of India had preferred the Committee's proposals for the Indian rupee to that of the Director-General. An element of risk was always involved in fixing any exchange rate. However, the Director-General, with the interests of the regional offices very much at heart, believed that his recommendations involved a reasonable risk which the Organization could handle managerially.

With regard to the proposals to set the Swiss franc/US dollar exchange rate at 2.64, he recalled that the Director-General's proposed rate of 2.50 had been set pursuant to an agreed methodology followed by all United Nations organizations in Geneva whereby the exchange rate on which budgetary proposals were based was the accounting rate of exchange at the time of preparation of those proposals. When the budget under scrutiny had been finalized in October 1984, the rate of exchange had been 2.50; it had remained so until December 1984. During that same period other organizations, including ILO, whose annual conference was to follow the present World Health Assembly, had also fixed their budgetary rates for the period 1986-1987 at 2.50 Swiss francs. If, therefore, WHO were to follow the proposals to adjust its budgetary rate to the latest accounting rate, there would be two organizations with budgets for the same biennium based on different rates of exchange solely on account of the timing of their annual meetings. He wondered whether that really made sense. Further, he noted that the delegates in favour of changing the rate of 2.64 were from Member States which usually pressed for harmonization among the specialized agencies: their proposals would
produce the opposite. Furthermore, the April rate of 2.64 had been set on 30 March 1985: the actual rate on 4 April had been 2.64, but on 19 April it had fallen to 2.46. The considerable day-to-day fluctuations should not therefore be taken into account, since the Committee was discussing an exchange rate not for tomorrow, nor for next week or next month, nor for the remainder of the year, but for the years 1986 and 1987.

The United States delegate had rightly pointed out that the casual income facility would give sufficient protection to the programme in 1986-1987 if the exchange value of the US dollar should fall below the budgetary rate of exchange of 2.64 Swiss francs per US dollar which that delegation proposed. However, the main problem was that casual income should be used primarily to help finance the regular budget and thus reduce assessments of Member States, as many delegates had stated so often. With over US$ 54 000 000 and now over US$ 56 000 000 of casual income available for the current budget and forthcoming budget respectively, the Organization had become dependent on casual income, which now financed over 10% of the regular budget. The casual income facility was in fact a safety-net to protect the programme in the event that the value of the US dollar fell below the budgetary rate of exchange between the dollar and the Swiss franc, and as a safety-net it should not be relied upon as a matter of course in setting a budgetary rate of exchange. If the budgetary exchange rate for 1986-1987 were set too high, as it might be at 2.64, and casual income had to be used, it would protect the programme in 1986 and 1987 but, by the end of 1986 when the Director-General's budget programme proposals for 1988-1989 were issued, there would be less than the US$ 56.7 million available as at 31 December 1984 and which was now being proposed to help finance the budget for 1986-1987. Any decrease in the casual income available to help finance the programme budget had a dramatic effect on Member States: if less than US$ 56.7 million were available at year-end 1986, the assessments of Members for the next budget would increase even if the budget level remained the same. The future of casual income earnings would also be jeopardized. The main reason why so much casual income had been available to help finance the 1982-1983, 1984-1985 and 1986-1987 budgets was that the budgetary exchange rate had been set at a level which made it possible to avoid having to resort to the use of casual income under the casual income facility and which resulted in very substantial budgetary surpluses for the biennia 1980-1981 and 1982-1983. Those surpluses, due solely to the fact that the average accounting rate of exchange had been consistently higher than the budgetary rate of exchange, had amounted to some US$ 18 000 000 in 1980-1981 and over US$ 12 000 000 in 1982-1983, and it could already be predicted that for the 1984-85 biennium the surplus due to exchange rate gains would be larger than ever. All those surpluses had been and would be transferred to casual income, as delegates were aware. If the budgetary rate of exchange for 1986-1987 were set at a level which turned out to be higher than the actual rates of exchange during that biennium, it would result in less casual income becoming available in 1988 to help finance the budget for 1990-1991, since there would be no budgetary surplus for 1986-1987 becoming available in 1988. Moreover, if the next budget, that for 1988-1989, had to have a lower budgetary rate of exchange than the one that was now being proposed for 1986-1987, that would inevitably result in a cost increase over and above any inflationary cost increases and would thus mean an increase in the effective working budget level for 1988-1989 even if there should be no increase in real terms and no inflationary cost increases at all.

Mr BOYER (United States of America) said he was not aware of any agreement in the United Nations system that the exchange rate used in a budget was to be the rate obtaining when the budget was prepared. When there was a significant change in the exchange rate, it was clearly permissible for any governing body to change a Secretariat proposal. The reason for the present meeting was to make a judgement on the proposals submitted to it. He was not aware of any prior agreement and recalled that four years previously it had indeed been decided to recalculate the budget at the rate in effect at the time. Delegates were not therefore violating any principle in asking to have the budget calculated at 2.64 Swiss francs to the US dollar; nor was it of any concern if the ILO budget were calculated at a different rate. On the other hand, he believed that the major contributors to international organizations held as a matter of policy that budgets should be calculated at the most recent exchange rate, and were not concerned about month-to-month consistency.

The Assistant Director-General had said that exchange rates had fluctuated a great deal in recent months, and had acknowledged that that was the reason why the casual income facility had been created. The problem was, however, that he did not seem to want to use the casual income facility; his concern was with saving money, and that was why he was advocating what were in effect two insurance policies: the casual income facility and a lower exchange rate. But what was the point of the former, if it was not to be used?

He would submit that recalculating the budget at 2.64 Swiss francs to the US dollar would not affect the programme; anything that could be done to reduce the assessments on Member States should be done. With no fewer than 49 countries unable to pay even part of
their assessments the previous year, the Organization was faced with a serious financial situation. The risks involved in deciding on an exchange rate of 2.64 Swiss francs to the US dollar would, he believed, be acceptable.

Mr FURTH (Assistant Director-General) said that, as could be seen from paragraph 8 on page 477 of document P8/86-87, it had in fact been agreed that a suitable common method among organizations in Geneva would be to take the most recent United Nations operational rate of exchange known at the time the estimates were finalized. The governing bodies of the various independent agencies could, however, change the rates if such a change was considered appropriate. There had been no consistent policy that budgets should be calculated at the most recent exchange rate. For example, at the time of the approval of the current budget by the Health Assembly in May 1983, the accounting rate of exchange had been 2.08 Swiss francs, but the budgetary rate of exchange actually adopted had been 2.16 Swiss francs as originally proposed by the Director-General.

The CHAIRMAN observed that three further issues had been raised within the issue of adjustments under discussion. The first concerned post adjustment savings, in which connection he would note that the Committee as a whole appeared to welcome the Director-General's proposal to reduce the provision for post adjustment at global and regional levels by the amount of estimated savings, namely US$ 3.2 million.

The second issue concerned the exchange rates used for calculating regional budgets; the Committee had before it a proposal by the Committee of the Executive Board and a further proposal by the Director-General. With one exception, delegations that had spoken had all supported the Director-General's proposal. If there was no objection, he would take it that there was a consensus in favour of that proposal.

It was so agreed.

The CHAIRMAN observed that the third issue related to the exchange rate between the US dollar and the Swiss franc. Alternative exchange rates of 2.50 Swiss francs and 2.64 Swiss francs had been proposed: the latter proposal had been supported by many speakers and opposed by two. If it were adopted, the Director-General would be requested to recalculate the budget accordingly. Were there any further views on the matter?

Mr BALAKRISHNAN (India) wished to place on record his delegation's concern at the long-term financial repercussions of piecemeal adjustments in exchange rates, affecting the financial aspects of only one biennial budget at a time.

The CHAIRMAN invited the Committee to vote on the proposal that the recommended budgetary rate of exchange for the proposed programme budget for 1986-1987 be 2.64 Swiss francs to one US dollar.

The proposal was rejected by 36 votes to 23, with 15 abstentions.

The CHAIRMAN concluded from the result of the vote that the exchange rate to be recommended by the Committee would be 2.50 Swiss francs to one US dollar.

Professor SHERIF (Libyan Arab Jamahiriya) reminded the Committee of the Director-General's statement at the morning plenary meeting, and stressed that the primary concern should be for the health of all the peoples.

The CHAIRMAN suggested that the Rapporteur be requested to include the Committee's recommendations with respect to budgetary rates of exchange and post adjustment savings for 1986-1987 in its report to Committee A, which the Committee would then review at a later meeting (see summary record of the third meeting, section 1).

Use of casual income to help offset adverse effects of currency fluctuations

The CHAIRMAN invited the Committee to consider the question of the facility to be granted to the Director-General to use available casual income to help offset any adverse effects that might result from currency fluctuations in 1986-1987.

Mr GRIMSSON (representative of the Executive Board) recalled that, in his report to the Executive Board reproduced in Annex 1 to document EB75/1985/REC/1, the Director-General had proposed that he be authorized in 1986-1987, as in previous bienniums, to charge against available casual income the net additional costs under the regular programme budget that
might result from differences between the WHO budgetary rate of exchange and the actual United Nations/WHO accounting rates of exchange with respect to the US dollar/Swiss franc relationship prevailing in 1986-1987, up to a maximum of US$ 20 million. Conversely, any savings arising from such differences would be transferred to casual income, provided that, having regard to inflationary trends and other factors that might affect the implementation of the regular programme budget, such transfers to casual income need not exceed US$ 20 million. The Executive Board had reviewed the Director-General's proposals and concluded that the casual income facility had proved useful in enabling the Director-General to carry out the programme as intended by the Board and the Health Assembly. The Executive Board had therefore adopted resolution EB75.R5, recommending that the Health Assembly adopt a resolution approving the Director-General's proposals.

Mrs GARCIA (Cuba) said that her delegation could not agree to the suggestion in operative paragraph 5 of the draft resolution recommended in resolution EB75.R5 that Members pay their entire contribution to a given biennial budget prior to or at the beginning of the financial period concerned. The developing countries were in an extremely difficult financial situation in which they were unable to implement all their development programmes, and they often found it impossible to pay their full annual contribution to the Organization. While it might be possible for certain countries with surplus resources to make such advance payments, the suggestion was unrealistic for the majority of countries. Her delegation therefore proposed that the second part of operative paragraph 5 of the draft resolution beginning with the words "and that the earnings of such income could be significantly increased", be deleted.

Dr BISKUP (Federal Republic of Germany) reiterated his concern with the wording of part of the draft resolution in resolution EB75.R5. It was not WHO's task to earn casual income. He therefore proposed that operative paragraph 5 be deleted.

Dr NSAN (Nigeria) shared the view of the delegation of the Federal Republic of Germany but suggested that the paragraph should be amended rather than deleted. He proposed the following wording: "Calls the attention of Members to the fact that the Organization's casual income earnings depend largely upon the timely payment by Members of their assessed contributions to the approved budget, and that these earnings could be significantly increased if Members were to pay their entire contribution to a given biennial budget prior to or at the beginning of the financial period concerned rather than in two equal instalments". The resolution in no way implied that Members were being called upon to pay all their contributions at the beginning of the year. It merely made a suggestion, which could be considered or rejected, and was not in the nature of a directive.

The CHAIRMAN asked the Nigerian delegate to submit his proposal in writing. It could then be considered, together with the proposals by the delegates of Cuba and the Federal Republic of Germany, at the next meeting.

The meeting rose at 17h35.
SECOND MEETING
Wednesday, 8 May 1985, at 15h15
Chairman: Mr R. ROCHON (Canada)

1. REVIEW OF THE FINANCIAL POSITION OF THE ORGANIZATION: Item 24 of the Agenda (continued)

Report on casual income, budgetary rates of exchange and other adjustments to the proposed programme budget for 1986-1987: Item 24.4 of the Agenda (Documents EB75/1985/REC/1, resolution EB75.R5, and A38/25) (continued)

Use of casual income to help offset adverse effects of currency fluctuations (continued)

The CHAIRMAN invited the Committee to consider the proposals by the delegations of Cuba, Federal Republic of Germany, and Nigeria concerning the resolution recommended for adoption by the Health Assembly in resolution EB75.R5.

Mr GRIMSSON (representative of the Executive Board) pointed out in response to the previous day's discussion that operative paragraph 5 of the recommended resolution was not an innovation; in fact, three previous Health Assemblies (in 1979, 1981 and 1983) had adopted identical operative paragraphs in resolutions relating to casual income. It was, however, clear that the call on Member States for timely payment had not had the desired effect, and it would thus be perfectly valid to reconsider, or even to delete, the paragraph.

Dr NSAN (Nigeria) said that in view of the explanation given by the representative of the Executive Board, his delegation would be willing to withdraw its proposed amendment and to support the proposal by the Federal Republic of Germany for deletion of operative paragraph 5.

Mrs GARCIA (Cuba) said she, too, was willing to withdraw her proposal in favour of that by the Federal Republic of Germany.

The proposal for the deletion of operative paragraph 5 was adopted.

The draft resolution recommended by the Executive Board in resolution EB75.R5, thus amended, was approved.

2. SCALE OF ASSESSMENTS: Item 26 of the Agenda

Assessment of New Members and Associate Members: Item 26.1 of the Agenda (Documents A38/7 and A38/19)

Mr PURTH (Assistant Director-General) introducing the item said that document A38/7 dealt with the assessment of Saint Christopher and Nevis, 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 3 December 1984. Accordingly, the Health Assembly had now to establish the assessment of that State in WHO. The assessment had been fixed at the minimum rate of 0.01% in the United Nations scale of assessments, and the Health Assembly might therefore wish to keep it at that minimum for 1984-1985 and for future financial periods, as recommended in document A38/7.

1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA38.4.
In considering the assessment 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 in assessing new Members for their year of admission. If that were done, and since Saint Christopher and Nevis had become a Member of the World Health Organization on 3 December 1984, the 1984 assessment would be reduced to one-ninth of 0.01%.

If the Committee agreed with the Director-General's assessment proposal for Saint Christopher and Nevis, it might wish to recommend the adoption of the draft resolution in paragraph 5 of document A38/7.

The draft resolution was approved.1

Mr FURTH (Assistant Director-General) next drew attention to document A38/19 concerning assessment of Brunei Darussalam 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 on 25 March 1985 a formal instrument of acceptance of that Constitution. The assessment of Brunei Darussalam had been fixed at the rate of 0.03% in the United Nations scale of assessments, and the Assembly might therefore wish to keep it at that level for 1984-1985 and for future financial periods, as recommended in document A38/19.

In considering the assessment for the financial period 1984-1985, the Health Assembly would no doubt wish to take into consideration resolution WHA22.6. If that were done, and since Brunei Darussalam had become a Member of the Organization on 25 March 1985, no assessment would be made on it in respect of 1984, and 1985 assessment would be reduced to one-third of 0.03%.

He drew the Committee's attention to the draft resolution contained in paragraph 5 of document A38/19, which should be amended in operative paragraph (1) by the addition of the phrase "the second year of the financial period" before "1984-1985".

The draft resolution, as amended, was approved.2

Scale of assessments for the financial period 1986-1987: Item 26.2 of the Agenda (Documents PB/86-87, EB75/1985/REC/1, Part II, chapter III, section (c), and A38/8)3

Mr FURTH (Assistant Director-General) said that in implementation of resolution WHA24.12, WHA26.21 and WHA37.9 referred to in paragraph 1 of document A38/8, the proposed scale of assessments for 1986-1987 had been calculated on the basis of the United Nations scale of assessments for the year 1983 to 1985, as approved by the United Nations General Assembly in resolution 37/125.

In the proposed WHO scale for 1986-1987, no country was assessed at a rate higher than in the United Nations scale for the years 1983 to 1985. The proposed WHO scale was the same as that adopted by the Health Assembly in May 1983 for the financial period 1984-1985, except that it had been amended to incorporate the assessments of the four new Members for which the Thirty-seventh World Health Assembly had fixed either provisional or definitive assessment rates in May 1984. The proposed 1986-1987 scale would need to be modified to provide for the assessments of Saint Christopher and Nevis and Brunei Darussalam just decided on. That would lead to a reduction by 0.01% in the assessment rates of those four countries whose rates, when worked out to six decimal places next qualified mathematically for rounding downwards by 0.01%, namely, Czechoslovakia, Sweden, Ukrainian SSR and USSR.

He drew the Committee's attention to the draft resolution in paragraph 4 of document A38/8.

Mr LO (Senegal) said that the previous day the Committee had had a useful discussion on the need for adjustments in budgetary exchange rates to take account of monetary fluctuations which had occurred up to April 1985. The Director-General was to be congratulated on his untiring efforts to achieve better utilization of available resources. However, although it was wise to provide for some operational flexibility in rates of exchange, the time had come to review the machinery for payment of contributions by Member States. The steady increase

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1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA38.5.

2 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA38.6.

in the number of countries in arrears in the payment of their contributions made it urgent to seek the underlying causes of the problem. He did not intend to propose any reduction in the rate of contributions, but merely wished to draw attention to the fact that the continuous rise in the value of the dollar brought with it a continuous increase in the cost - in local currency - of contributions paid by countries such as his own; in fact, the difference in cost between the time when assessments were fixed and the moment of payment of contribution could amount to as much as 10% to 20%. Studies should be carried out to find an effective solution if the problem was not constantly to recur.

Dr BLANCO (Argentina) expressed a reservation in regard to the scale of assessment proposed for the period 1986-1987. That scale was based on the United Nations scale for 1983-1985, and did not take into account the social and economic changes which had occurred recently in many developing countries as a consequence of the recession and increased external indebtedness, which were having an adverse effect on health and the health-for-all strategy.

In the case of Argentina, the criteria used for assessment were now completely obsolete. The regime of 1976-1983 had pursued an economic policy which undervalued the dollar, resulting in an illusory increase in GNP. Since 1984, the new Government had tried to reverse that situation and to remedy social inequities, but its efforts were being hampered by the economic crisis. She urged that the criteria for establishing scales of assessment be reviewed to take into account the real current social and economic situation of many countries.

Dr QUIJANO (Mexico) said that, although his delegation accepted that the WHO scale of assessments had been calculated on the basis of the United Nations scale of assessments for 1983-1985 adopted by the United Nations General Assembly in 1982, it must be pointed out that when that resolution had been adopted, Mexico had voted against it and had drawn attention to the greater impact which the increases would have on oil-producing developing countries such as Mexico and to the fact that the parameters used by the Committee on Contributions were unrealistic in the light of the serious economic and financial situation facing the developing countries. On that occasion the Mexican delegation had maintained that the Committee on Contributions had not taken into account the real capacity to pay and the level of indebtedness deriving from inequalities in foreign trade relations, which had been deteriorating as a result of the fall in the prices of raw materials.

In the specific case of Mexico the Committee on Contributions had proposed an increase of 20 points, from 0.77 to 0.97%. Fortunately, a reduction had been obtained and Mexico's assessment had been fixed at 0.88% and, in WHO, at 0.86%. Nevertheless, for the reasons outlined, his delegation wished to enter a reservation in respect of the scale of assessments about to be adopted for WHO for the financial period 1986-1987.

Dr GEORGIEVSKI (Yugoslavia) said that his delegation wished to enter a reservation regarding the scale of assessments for the financial period 1986-1987, for the reasons already explained by the delegations of other developing countries.

Mr JOBARTEH (Gambia) said that in order to reduce the serious difficulties faced by developing countries and their dependence on the charity of the developed world, the scale of assessments needed to be more carefully examined. Even though it might not be possible for WHO to operate accounts in local currencies, consideration should be given to the foreign exchange problems encountered by developing countries in transmitting funds to the Organization. Gambia, for instance, had been endeavouring for the past three months to transmit its contribution in full, but the moneys had not yet reached Geneva.

A disturbingly large number of developing countries were in arrears of payment. The delays in making payments were not due to any intention to default but to the difficult circumstances in which those countries found themselves. They therefore needed to be treated more sympathetically when the scale of assessments was fixed.

Mr FURTH (Assistant Director-General), replying to points raised by members, explained that WHO itself had very little to do with fixing the scale of assessments. The scale which the Organization applied was basically the latest United Nations scale, adjusted to allow for the difference in membership. Nevertheless, the points made by various delegations had recently been taken into account by the United Nations General Assembly, which, after a very long debate in its Fifth Committee, had adopted without a vote the report of that Committee containing a resolution which instructed the General Assembly's Committee on Contributions to apply a number of new criteria when determining the next scale of assessments.

Among other steps, the upper limit of the low per capita income allowance formula was to be raised from US$ 2100 to US$ 2200 - a measure that would definitely be of some assistance
to the least developed among developing countries; in the redistribution of the burden of relief, the Committee on Contributions was to apply a limit to the relief burden borne by Member States to take into account their developmental status and developmental requirements; the individual rates of assessment of the least developed countries were not to exceed the present level; and the Committee on Contributions was to evolve a methodology to take into account the problems arising from the serious economic and financial situation in the world. The next scale of assessments would be effective in the United Nations as from 1986, and in WHO as from 1987 or 1988. Thus the next WHO scale of assessments was likely to incorporate some changes to alleviate the burden borne by the poorer countries.

Dr NSAN (Nigeria) asked why South Africa had been included among the Member States listed in the annex to document A38/8.

Mr JOBARTEH (Gambia) welcomed the information provided by the Assistant Director-General. However, the measures to be taken to relieve the burden borne by the developing countries would still seem to be of doubtful effectiveness if, after a certain period of time, a Member State was penalized for being in default without a careful examination being made of the reasons for the default. In the light of the present financial and economic constraints faced by the developing countries, their position should be sympathetically reviewed and mechanisms should be established to help them, either in the form of WHO utilization of local currencies or of assistance with the remittance of funds to WHO headquarters.

Mr FURTH (Assistant Director-General), replying to the question put by the delegate of Nigeria, explained that South Africa had been included in the scale of assessments because it was a Member State of WHO and was therefore assessed like all other Member States. The only difference was that South Africa was not participating in the work of the Organization and was therefore not paying its contribution. That was why, in the Appropriation Resolution, there was a difference between the total budget and the effective working budget, the uncollected contributions of some Members - namely South Africa, the Ukrainian SSR and the Byelorussian SSR - being credited to the undistributed reserve.

He was unable to reply in detail to the comments made by the delegate of Gambia because he was not fully acquainted with the precise problem referred to. WHO tried to inform governments of the accounts into which contributions should be paid. In that connection the delegate of Cameroon had made a very pertinent suggestion at the previous meeting, and the Secretariat would certainly make sure that the account numbers were more effectively publicized. He was aware that the transfer of funds through the international banking system sometimes took a very long time - in some cases up to four weeks.

The question of payment in local currencies had been examined by the Executive Board and the Health Assembly on several occasions. Some years ago, the Director-General had made a very comprehensive proposal in that respect, but obviously satisfaction could not be given to all countries because the amounts of local currency which WHO required for its operations were rather limited.

The CHAIRMAN drew the Committee's attention to the draft resolution contained in paragraph 4 of document A38/8.

The draft resolution was approved.¹

3. WORKING CAPITAL FUND: Item 27 of the Agenda

Review of the Working Capital Fund: Item 27.3 of the Agenda (Document EB75/1985/REC/1, resolution EB75.R11 and Annex 4)

The CHAIRMAN drew attention to Annex 4 to document EB75/1985/REC/1, which contained a report on the review of the Working Capital Fund submitted by the Director-General to the Executive Board at its seventy-fifth session. Following the discussion of that item the Executive Board had decided to recommend a draft resolution for adoption by the Health Assembly. That draft resolution was contained in resolution EB75.R11.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA38.7.
Mr GRIMSSON (representative of the Executive Board) informed the Committee that the Executive Board, when considering the report by the Director-General, had noted that the Working Capital Fund had last been reviewed at the Thirty-fifth World Health Assembly in 1982. At that time the Health Assembly had adopted resolution WHA35.9 which, inter alia, requested the Director-General to submit further reports on the Working Capital Fund to the Executive Board and to the World Health Assembly when he considered it warranted and in any case not less frequently than every third year.

The Director-General’s report dealt with three major points. The first and most important one concerned the authorized level of the Working Capital Fund and its adequacy to meet the needs for which it had been established. The Board had been informed that contributions collected by 31 December 1984 represented 93.88% of the contributions due in 1984 for the effective working budget. As compared with the previous five years, the rate of collection had been lower than the corresponding percentages in the years 1979, 1980, 1982 and 1983 but higher than the rate for 1981.

As at 31 December 1984, of the 158 Members and Associate Members contributing to the effective working budget, only 84 had paid the 1984 instalment of their contributions for the financial period 1984-1985 in full; 25 had paid in part, no fewer than 49 Members had not yet paid any part of their 1984 assessment. In addition, 37 of those 49 Members owed contributions due in respect of years prior to 1984. The number of Members and Associate Members contributing to the effective working budget that had not made any payment towards their current year’s contribution by the end of the year in which the contribution was due had more than quadrupled in the past five years, rising from 11 to 49.

Such a deterioration in the rate of collection of contributions would, in other circumstances, have resulted in the withdrawal of cash from the Working Capital Fund to finance regular budget obligations. It might also have been necessary, in other circumstances, to borrow from other internal funds, under the authority vested in the Director-General by Financial Regulations 5.1 and 6.3. That, however, had not been necessary, for two reasons. Firstly, the cash available from the receipt of regular budget contributions had been supplemented by casual income appropriated to help finance the budget. Those casual income appropriations had become effective on the first day of each financial period and had amounted to US$ 24,400,000 and US$ 54,500,000 for the financial periods 1982-1983 and 1984-1985 respectively. Secondly, the Organization had spent less in dollar terms than had been budgeted, mainly due to net savings resulting from the differences between the WHO budgetary rates of exchange and the United Nations/WHO accounting rates of exchange for the US dollar/Swiss franc relationship. During the financial period 1982-1983 that factor had contributed to net savings of US$ 12,113,000. When the Executive Board had met in January 1985 it had felt that it was too early to predict whether any such net savings were likely to be realized at the end of the current 1984-1985 financial period. However, at the end of 1984 there had been no doubt that the net savings deriving from that factor during the first year of the biennium had contributed to the satisfactory cash situation. For those reasons, and in view of the borrowing authority granted to the Director-General by Financial Regulations 5.1 and 6.3, the Board had concurred with the Director-General’s proposal that, for the time being, no modification should be made to the authorized level of the Working Capital Fund.

However, it should be stressed that the Executive Board shared the Director-General’s concern regarding the implications of continuing delays in the payment of contributions. Such delays could, in certain circumstances, lead to withdrawals from the Working Capital Fund, to borrowing of funds from other internal sources, and possibly also to higher assessments on Member States should it become necessary to appropriate funds from casual income earnings to increase the Working Capital Fund. The Board had noted that the Director-General would continue his efforts to secure early payment of contributions and that he would continue to keep under review the adequacy of the level of the Working Capital Fund and would report, when warranted, to the Executive Board and Health Assembly.

The second major point in the Director-General’s report related to the conditions and limitations governing withdrawals from the Working Capital Fund to meet unforeseen extraordinary expenses and to finance the provision of emergency supplies to Members and Associate Members on a reimbursable basis. The Board had endorsed the Director-General’s recommendation that the existing limits, which had been established in resolution WHA35.9, should not be modified.

The third major point in the Director-General’s report concerned the reassessment of the present advances of Members and Associate Members to Part I of the Working Capital Fund. Those advances had been fixed in 1982, in accordance with resolution WHA35.9, on the basis of the scale of assessments for the financial period 1982-1983, adopted in May 1981. Since 1981 the Membership of the Organization had increased and changes had occurred in the scale of assessments. The Board had endorsed the Director-General’s recommendation that advances of Members and Associate Members to Part I of the Working Capital Fund should be reassessed on
the basis of the scale of assessments for the financial period 1986-1987 to be adopted by the current World Health Assembly. An appendix to the Director-General's report showed the decreases and increases in the present advances that would result from the application of the proposed WHO scale of assessments for the financial period 1986-1987 as presented in the programme budget document, subject to adjustment for new Members or Associate Members joining the Organization after 30 September 1984. The Board had also endorsed the Director-General's final recommendation to the effect that any adjustments increasing Members' and Associate Members' advances to Part I of the Working Capital Fund should become due and payable on 1 January 1986 and that any credits due to Members and Associate Members should be refunded on 1 January 1986 by applying them to any contributions outstanding on that date or to the 1986 assessments.

Finally, the text of a draft resolution recommended for adoption by the Health Assembly was contained in resolution EB75.R11.

The draft resolution recommended by the Executive Board in resolution EB75.R11 was approved. ¹

4. REAL ESTATE FUND: Item 28 of the Agenda (Document EB75/1985/REC/1, resolution EB75.R12 and Annex 5)

The CHAIRMAN, introducing the item, said that the Executive Board had, at its most recent session, discussed the Director-General's report contained in Annex 5 to document EB75/1985/REC/1 and had adopted resolution EB75.R12, recommending a resolution for adoption by the Health Assembly.

Dr HAPSARA (representative of the Executive Board) said that the Executive Board had noted the status of implementation of the approved projects under the Fund for the period up to 31 May 1985, as well as the estimated requirements of the Fund for the period 1 June 1985 to 31 May 1986, as listed in the Director-General's report. It had noted that the Regional Office for the Americas would not proceed with the building of a joint PAHO/WHO documentation centre in Mexico, since for reasons of efficiency and economy it had been decided to transfer the publications and translation services to the Regional Office in Washington. The Board had supported a proposal that for future real estate activities in the Region of the Americas, a PAHO/WHO cost-sharing formula should be worked out, for review by the Board and the Assembly, bearing in mind the proportion of WHO-financed staff working in that region. The Board had adopted resolution EB75.R12 recommending the authorization by the Thirty-eighth World Health Assembly of the financing of the expenditures, as indicated, from the Real Estate Fund at an estimated cost of US$ 190 000.

The draft resolution recommended by the Executive Board in resolution EB75.R12 was approved. ²

5. SALARIES AND ALLOWANCES FOR UNGRADED POSTS AND THE DIRECTOR-GENERAL: Item 29 of the Agenda (Document EB75/1985/REC/1, resolution EB75.R10 and Annex 3)

Mr GRIMSSON (representative of the Executive Board) said that the Executive Board, at its seventy-fifth session in January 1985, had confirmed the amendments to the Staff Rules made by the Director-General, including the consolidation into base salaries of a portion of the cost-of-living adjustment, with a corresponding reduction in that cost-of-living element so as to maintain the same level of total remuneration. The Board had considered that the same technical adjustment should be made in the remuneration of ungraded posts and of the Director-General, and had consequently adopted resolution EB75.R10, recommending to the Thirty-eighth World Health Assembly the adoption, in accordance with Staff Regulation 3.1, of a resolution which would establish new figures for the gross and net salaries of the Assistant Directors-General, Regional Directors, the Deputy Director-General and the Director-General. The proposed resolution noted that, concurrent with those changes in

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA38.8.
² Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA38.9.
salary schedules, an appropriate reduction would be made in the post adjustment applicable to those posts. It was also recommended that the adjustments in the distribution of total remuneration between base salary and post adjustment should be effective from 1 January 1985, as was the case for the professional categories including the Director level. The technical adjustments to the two major elements making up total remuneration were made on the basis of a no-gain, no-loss formula and were mutually compensatory. The General Assembly of the United Nations, on the recommendation of the International Civil Service Commission, had approved identical changes in the salaries and allowances for ungraded posts in the United Nations.

The draft resolution recommended by the Executive Board in resolution EB75.R10 was approved.\(^1\)

6. RECRUITMENT OF INTERNATIONAL STAFF IN WHO: BIENNIAL REPORT: Item 30 of the Agenda (Resolution WHA36.19; Document EB75/1985/REC/1, resolution EB75.R8 and Annex 2)

The CHAIRMAN recalled that the subject had been discussed at the last session of the Executive Board on the basis of a report by the Director-General, reproduced in Annex 2 to document EB75/1985/REC/1. The Board had subsequently adopted resolution EB75.R8 contained in the same document.

Dr HAPSARA (representative of the Executive Board) said that the Director-General's report had been presented to the Board in accordance with the request contained in resolution WHA36.19. The report had reviewed the progress made between October 1982 and October 1984 in improving the geographical representation of the staff, as well as the evolution of the situation over the same period regarding the proportion of posts occupied by women. It showed that the progress reported to the seventy-first session of the Board and the Thirty-sixth World Health Assembly in improving geographical representation had been fully sustained in the two-year period under review: the 40% target for appointments from unrepresented and under-represented countries had been met; the number of nationals of over-represented countries had gone down significantly, by 86 staff members, or 32%, but although 6 new Member States had joined the Organization over the two-year period the number of unrepresented countries had not increased and, without the new Members, would have decreased from 40 to 35 in that period. The number of adequately represented countries had increased from 77 to 82. It had further been reported to the Board that since 1973 the percentage of Member States and Associate Members represented on the staff had remained constant at about 75%, and that there was a good balance between developed and developing countries among the States represented.

Although the trend with regard to the number of women staff members had not been as satisfactory as that of geographical representation, the Board had welcomed the Director-General's initiative in recruiting a consultant, Dr Maureen M. Law, a former Chairman of the Board, to advise him as to how the Organization might effectively increase the number of women recruited. Dr Law had addressed the Board about her study for the Director-General. Although statistically the number of women in WHO was at a fairly satisfactory level, there was no doubt that more intensive efforts could be made to recruit qualified women health professionals, and in that connection Dr Law had particularly emphasized the need to identify suitably qualified women candidates. The recommendations in her report would concentrate on that aspect and on the desirability of increasing the number of women serving as consultants, as members of advisory panels, on the Executive Board and on delegations to the Health Assembly. It was important that Member States should give their full support in the identification of suitable women candidates. The inclusion of women in such bodies would increase their chances of recruitment by WHO, and Dr Law found it hard to believe that suitable candidates did not exist. She had stressed the need for equal treatment of women in the recruitment process, and had made it clear that she was urging fair but not necessarily special treatment.

As the record of its discussions showed, the Board had expressed its appreciation of the progress achieved both in increasing the geographical representativeness of the Secretariat and in the recruitment of women. To encourage the efforts of all parts of the Organization and particularly of Member States in recommending qualified women candidates, the Board had proposed that the target for the proportion of women in professional and higher-grade posts be increased from 20% to 30%, on the understanding that that might take some time to achieve.

\(^1\) Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA38.10.
The Board's recommendations on those matters were embodied in the text of the draft resolution recommended for adoption by the Thirty-eighth World Health Assembly and contained in resolution EB75.R8. The record of the Board's discussions would be found on pages 331-339 and 343-345 of document EB75/1985/REC/2.

Mr FURTH (Assistant Director-General) said that it was heartening to be able to report that, in terms of the geographical representativeness of the staff, all the positive trends which had been reported to the Executive Board in January had been fully maintained in the six-month period from 31 October 1984 to 30 April 1985.

First, the number of nationals of over-represented countries had gone down by a further 9%, which was fully commensurate with the 32% drop recorded in the full two-year period from October 1982 to October 1984. Secondly, in terms of the representation of countries among the staff, the number of adequately represented countries, to which he had referred at the Executive Board as "the ultimate test of geographical representativeness of the staff" had increased from 82 to 86; the number of over-represented countries had fallen from 27 to 25, and the number of under-represented countries had also gone down from 13 to 12. Further, even though two new Member States had joined the Organization, the number of under-represented countries had increased by only 1, from 40 to 41. While it was desirable that the group of countries unrepresented on the staff should be much smaller, it was important to note that a large number of countries in that group had only recently become Members of WHO: many were characterized by their extremely small population, and a significant number of the countries in that group required the services of all their own health specialists.

It was also encouraging to be able to report the attainment of the somewhat elusive target of 20% of all professional and higher-ranked posts in established offices filled by women. By April, the percentage was 20.04% and had been achieved just in time as WHO was embarking on the task of reaching the 30% target in the next few years, as recommended by the seventy-fifth session of the Executive Board.

The CHAIRMAN drew the Committee's attention to the following amendments proposed by the delegation of Mongolia to the draft resolution contained in resolution EB75.R8.

1. Second preambular paragraph: to be deleted.
2. Insert a new second preambular paragraph reading:
   "Desirous of further strengthening the progress already achieved in eliminating anomalies of geographical distribution of staff and ensuring that by year 2000 every country is represented at an appropriate level;"
3. Insert a new third preambular paragraph reading:
   "Recognizing that resolution WHA36.19, adopted earlier, concerning the filling of 40% of vacancies by citizens of countries that are inadequately represented or not represented at all, cannot fully and adequately ensure the achievement of this goal;"
4. In the present third preambular paragraph (which becomes fourth):
   after the word "Noting" insert the words "the slowness of".
5. In the first operative paragraph, the first line should read:
   "DECIDES to establish a target of 60% of all vacancies arising in professional and".

Dr JADAMBA (Mongolia), introducing his delegation's amendments, said that all Member States must have an opportunity to be represented on the Organization's staff, but that was not adequately reflected in the draft resolution recommended in resolution EB75.R8. Of the 161 countries listed in Appendix 1 of Annex 2 to document EB75/1985/REC/1, 114 had a desirable range of one to eight posts in WHO. That meant that, if one of their citizens was appointed, those countries were then regarded as adequately represented, a situation that could adversely affect the interests and efforts of the countries concerned. Efforts should be made to establish uniform criteria applicable to all Member States for determining whether countries were under-represented or not. There was a need for a more realistic approach in implementing the principles governing the recruitment of international staff. If, as in the past, 60% of vacant posts were filled by candidates from over-represented or adequately represented countries and 40% by nationals of unrepresented and under-represented countries, that would increase the anomalies in geographical distribution. The draft resolution recommended by the Executive Board for adoption by the Health Assembly failed adequately to reflect the principles expressed in resolution 31/26 of the United Nations General Assembly with respect to geographical distribution. His delegation's amendments would in no way jeopardize the interests of Member States and could make an important contribution to the practical implementation of the principle of equitable geographical distribution. They were designed to achieve a more balanced representation by the year 2000.
Mr GUNNARSSON (Iceland), welcoming the thorough review of the Director-General's report by the Executive Board at its seventy-fifth session, observed that progress had been made in improving the geographical representativeness of professional staff. He wished to express some concern, however, as to the recruitment of international staff, and to draw attention to unreasonable obstacles to secretarial staff recruitment. With respect to international staff, his delegation was concerned at the slow progress being made in reducing the number of unrepresented and under-represented countries in the professional category, and therefore urged the Director-General and Regional Directors energetically to pursue their efforts to improve both the geographical representativeness of staff and the proportion of posts occupied by women, in accordance with operative paragraph 4 of the draft resolution recommended for adoption by the Health Assembly in resolution EB75.R8.

The criteria for the recruitment of general service staff should be brought up to date. Since the invention of the dictaphone, few secretaries with shorthand skills were to be found. Staff from countries having one of the main official languages as their mother tongue were at a great advantage. The recruitment of general service staff from a broader spectrum of Member States should be encouraged.

He supported the draft resolution recommended in resolution EB75.R8.

Dr GUZMAN VELIZ (Chile) said that his delegation supported the continuing efforts being made to obtain improved geographical representativeness. It must be recognized, however, that the number of candidates available from under-represented countries was limited. In addition, the Director-General needed suitable personnel to fill vacant posts in order to enable the Secretariat to perform its many and varied duties. Both the percentages proposed by the Executive Board and the draft resolution were acceptable to his delegation.

Mrs WOLF (German Democratic Republic) welcomed the progress staff made between October 1982 and October 1984 in improving the geographical distribution of staff and the recruitment of women in WHO. During that period, the German Democratic Republic had moved from the category of unrepresented countries into that of under-represented countries; one of the nine women recruits mentioned in Annex 2 to document EB75/1985/REC/1 was from the German Democratic Republic; the situation was still unsatisfactory, however, and it would continue its efforts to propose qualified candidates for WHO vacancies. The results achieved nevertheless represented encouraging progress towards implementing the principle of equitable geographical distribution. That was not only in the interest of Member States but was indispensable for ensuring that the Secretariat performed its duties properly and effectively. The question of using the experience of representatives from various regions and countries with differing social systems had been raised repeatedly by many delegations on earlier occasions.

Further measures would have to be taken, since 53 countries were still unrepresented or under-represented. That was too high a figure, even taking into account the difficulty that, in many cases, staff were urgently needed in their own countries. Wholehearted and consistent support of the Director-General's efforts by those concerned, both at headquarters and in the regional offices, was essential.

With respect to the appointment of women to professional and higher-grade posts, her delegation supported the proposed increase to 30% on the understanding that the preferential recruitment of women would be carried out in accordance with the principle of equitable geographical representativeness.

Her delegation supported the amendments proposed by the Mongolian delegation.

Professor ISAKOV (Union of Soviet Socialist Republics) observed that the Director-General's report in Annex 2 to document EB75/1985/REC/1 provided detailed information on the considerable amount of work carried out by the Secretariat in the area of international staff recruitment in 1983 and 1984. It was clear that the changes that had taken place with respect to the geographical representation of States had been in the right direction. Nevertheless, more than 50 countries - nearly one-third of the Member States of the Organization - fell into the unrepresented or under-represented category. The importance of recruitment on the broadest possible geographical basis must be constantly kept in mind. He therefore supported the Mongolian delegation's proposal that the target of 40% mentioned in the first operative paragraph of the draft resolution recommended for adoption by the Health Assembly should be increased to 60%.

He hoped that when the Health Assembly re-examined the question in 1987, there would have been even more favourable developments with respect to the recruitment of international staff.

Dr DEL RIO (Spain) said that, although there had been some improvement over the two-year period in the geographical representativeness of staff, the progress made had been
insufficient. Further efforts should be made to reduce inequalities so that the position of unrepresented or under-represented countries such as Spain - which had lost four posts during the past two years - was improved. His delegation supported the amendments proposed by the Mongolian delegation, and particularly the proposal to replace the 40% target mentioned in the first operative paragraph of the draft resolution by one of 60%.

Dr HASEGAWA (Japan), expressing his gratitude to the Director-General for his efforts to deal with the problem of unrepresented and under-represented countries, said that Japan particularly appreciated the sending of a WHO mission headed by the Assistant Director-General, Mr Furth, to Japan to recruit Japanese nationals for service with WHO. Continuation of the Secretariat's efforts to increase the number of Japanese nationals on WHO staff would be welcomed as Japan was one of the most severely under-represented countries.

Mrs OLSZ (Hungary) expressed her satisfaction with the Director-General's efforts to improve the geographical representativeness of WHO staff in pursuance of Article 35 of the WHO Constitution and resolution WHA36.19. Much, however, still remained to be done since unrepresented and under-represented countries made up nearly one-third, and over-represented countries about 15%, of all WHO's Member States. Although it was encouraging to note that the number of adequately represented countries had increased from 77 to 82, many countries were represented at the lower limit of the desirable range while others were at the opposite extreme. Hence, in the years to come, it was essential that WHO should achieve proper geographical representativeness. For that reason she supported the amendments proposed by the Mongolian delegation.

Mr LUPPTON (United Kingdom of Great Britain and Northern Ireland) said that the United Kingdom appreciated WHO's success in increasing by a modest but significant amount the proportion of women and of nationals from unrepresented or under-represented countries among the staff. It supported the continuation of those efforts and the adoption of the draft resolution contained in resolution EB75.R8. However, while the goal of equitable geographical distribution (as laid down in the Charter of the United Nations) should be pursued, the other goal mentioned in the Charter and in the WHO Staff Regulations - that of ensuring the highest standards of efficiency, competence and integrity amongst recruits - should be kept fully in mind.

Mr FERAA (Morocco) said that the question of recruitment had been raised every year in Committee B. Thanks to the efforts of many delegations, the geographical representativeness of the staff had been improved in a manner satisfactory to all the Member States of the Organization. A great effort had been made by the Secretariat, but it was evident from the Director-General's report on the subject that a fairly large number of countries were unrepresented or under-represented. WHO, which was a world organization, was also an institution for the training, not only of its own officials so as to enable them successfully to carry out their functions, but also of skilled people from many countries, and particularly developing ones, so that they would gain experience that would subsequently be of benefit to them in serving their own countries. The Secretariat was thus to be commended for its efforts, and it was to be hoped that the number of unrepresented countries would continue to decrease.

Dr REILLY (Papua New Guinea) said that Papua New Guinea appreciated the progress that had been made in improving the geographical representativeness of staff and the recruitment of women to the Organization. As a representative of one of the Pacific islands (six of which were unrepresented countries), he believed that he could speak for them all in saying that they had only a limited number of highly qualified staff, whose recruitment by WHO would make it difficult to maintain and improve existing services. In addition, he endorsed the view expressed by the delegate of the United Kingdom that, since Member States expected WHO staff to be of the highest quality possible, that should be the main criterion for recruitment. For those reasons, he was uncertain whether increasing the target for the appointment of nationals from unrepresented and under-represented countries to 60% would really be in the best interests of his country.

Mr CAO Yonglin (China) said that the recruitment of international staff in WHO had been a matter of concern to Member States for many years and had been frequently discussed by the Executive Board and the Health Assembly. China appreciated the efforts made by the Director-General in recent years to improve the geographical representativeness of staff. The number of unrepresented and under-represented countries had been reduced and qualified staff had been selected from an increasing number of countries. In the recruitment of international staff in WHO, attention should be paid, first, to the need to ensure that such
staff were of the highest competence, and, secondly, to the need for wide geographical representation. Attention to those two points was in the best interests of WHO and its Member States, especially with regard to the implementation of the strategy and plan of action for health for all by the year 2000. It was therefore to be hoped that WHO would continue its efforts in the two areas mentioned.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean) noted that in the Eastern Mediterranean five countries were not represented at all on the WHO staff and two others were represented by no more than one or two persons. Similar situations were experienced by other regional offices. A point that no speaker had yet raised was that of representation according to various grades of staff. It was a fact that some countries, although adequately represented, had their nationals in such low grades that they could be said to have very little effective representation. In addition, in line with what the delegate of Papua New Guinea had said, recruitment in the Eastern Mediterranean was hampered by the fact that in certain countries the number of suitably qualified people available for recruitment was very limited. Hence, recruitment from such countries was almost impossible. The difficulty was further compounded by the need for preferential recruitment of women. It had happened on a number of occasions that a post had had to be advertised more than once. There was a further obstacle to recruitment from under-represented countries in the Eastern Mediterranean in that the Regional Office salary structure was less good than that on offer in some countries. In an attempt to solve some of those difficulties, the Regional Office had embarked on a training scheme in which two persons had been recruited from unrepresented countries to fill two posts as trainees for two years, after which they would either join WHO as staff members or return to their countries, taking the benefit of their WHO experience with them. Maintenance of the present target of 40% of vacancies for the appointment of nationals from unrepresented or under-represented countries required great efforts. Increasing that figure to 60% (especially when compounded by the need to recruit more women) would make the task even more burdensome.

Dr JADAMBA (Mongolia) said that he was unable to agree with those speakers who had implied that highly qualified experts were available only from the developed countries. The developing countries were, on the contrary, the best source of experts competent to deal with the problems of those countries on a level of equality with experts from the developed countries.

Mr FURTH (Assistant Director-General), replying to the comment by the delegate of Iceland that WHO should recruit general service staff from a broader spectrum of Member States, said that the sole criteria operative throughout the United Nations system for the recruitment of general service staff were qualification for the post and cost. The latter meant that as far as possible such staff were recruited locally, irrespective of nationality. The availability of candidates, a point touched on by many speakers, played an important part in country representation. If WHO was to engage a national from a given country, either a candidate from that country would have to come forward himself or his candidature would have to be submitted by his country. The fact was that some Member States did not wish to be represented on the WHO staff and others were unable to present candidates. Twenty of the 40 countries unrepresented on the WHO staff had no candidates on the Organization's recruitment roster, and for most of them candidatures had never been received. That was a situation that would take a long time to rectify despite all the efforts expended by the Director-General and the Secretariat to identify suitable candidates from those countries.

Whether developed or developing countries provided the best candidates was not a point at issue. An examination of the list of the 27 over-represented countries would show that all of them, with the exception of two, were developing countries. The list of 82 adequately represented countries showed that the overwhelming majority of them (63 countries) were developing countries. Hence the developing countries were numerically better represented on the staff of WHO than the developed countries.

With regard to the target of 60%, it should be noted that WHO and the United Nations were the only organizations in the United Nations system to have set percentage targets at all. In the United Nations the target for the recruitment of staff from unrepresented and under-represented countries was also 40%. However, the United Nations, in achieving an actual figure of 20.5%, had not done nearly as well as WHO, which over the past two years had achieved a figure of 40.3%. The list of over-represented countries on the United Nations staff had, as stated during the 1984 General Assembly, been growing longer; in WHO it had been shortening. ILO for its part, as shown in a Joint Inspection Unit report issued in 1984, had 49 unrepresented Member States (as opposed to 40 in WHO) and 36 under-represented ones (as opposed to 13 in WHO).
It was abundantly clear from Article 35 of the WHO Constitution that the paramount consideration was to assure the efficiency, integrity and internationally representative character of the Secretariat. The fact that, according to that Article, "due regard" only should be paid to the importance of recruiting staff on as wide a geographical basis as possible clearly showed that that factor was secondary to, or of lesser priority than, efficiency, competence and integrity. The Director-General in his interventions on the subject in the course of the very full debate on the issue in the Executive Board had said, "It would be highly undesirable to include any provision in the instructions given to the Director-General that might in any way create difficulties for him in carrying out his constitutional responsibility towards all Member States". A higher target than 40%, if adopted as an instruction to the Director-General from the Health Assembly, would undoubtedly constitute such an obstacle.

(For continuation of discussion, see summary record of the third meeting, section 3.)

The meeting rose at 17h35.
THIRD MEETING

Thursday, 9 May 1985, at 14h30

Chairman: Mr R. ROCHON (Canada)

1. REPORT OF COMMITTEE B TO COMMITTEE A (Document A38/27)

Dr JAKAB (Hungary), Rapporteur, read out the draft report of Committee B to Committee A.

Mr BALAKRISHNAN (India) asked in what form an account of the Committee's deliberations on matters concerning the US dollar/Swiss franc budgetary exchange rate would appear in the report.

The CHAIRMAN said that, since the Committee's deliberations on those matters were in the summary records, no such account would be included in the report. In any case the Committee had decided to accept the Director-General's recommendation.

The report was adopted (see document WHA38/1985/REC/2).

2. FIRST REPORT OF COMMITTEE B (Document A38/28)

Dr JAKAB (Hungary), Rapporteur, read out the draft first report of Committee B.

The report was adopted (see document WHA38/1985/REC/2).

3. RECRUITMENT OF INTERNATIONAL STAFF IN WHO: BIENNIAL REPORT: Item 30 of the Agenda (Resolution WHA36.19; Document EB75/1985/REC/1, resolution EB75.R8 and Annex 2) (continued from the second meeting, section 6)

Mr PALSSON (Iceland) expressed his appreciation of the efforts being made by the Director-General to achieve an equitable geographical distribution of staff. His delegation was particularly anxious, however, that the requirements as to the formal education and other qualifications of general service staff should be brought up to date.

Mr FORMICA (Italy) also expressed his appreciation of the efforts being made by WHO to achieve equitable geographical representation in the Secretariat. Although the basic criterion for selection must remain the professional qualifications of each candidate, it was very important that the Organization should be able to benefit from experience acquired all over the world. For a number of reasons Italy's representation was currently at its lowest ever. While not wishing to insist on a percentage figure, his delegation hoped that candidates from unrepresented or under-represented countries would continue to receive all due attention, other conditions being equal, and particularly with regard to competence. The current arrangements for making Italian associate experts available to WHO could lead to new and adequately qualified staff being placed at the Organization's disposal.

Dr MORK (Norway), speaking on behalf of the Nordic countries, said that the Director-General's report on the recruitment of international staff by WHO showed that the geographical representativeness of the Organization's staff had improved significantly from October 1982 to October 1984 in spite of the fact that six new Member States had joined WHO and that the number of staff subject to the principle of equitable geographical distribution had declined. Further progress had clearly been made since October 1984. In view of WHO's impressive record in the matter, the Nordic delegations hesitated to support the Mongolian
proposal to increase the target for the appointment of nationals of unrepresented or under-represented countries from 40% to 60% when the full consequences of such a drastic step were not known, although they would very much like to see the list of unrepresented countries considerably shortened.

In his report, the Director-General described some of the difficulties which the Organization faced in pursuing the present target of 40%, and Mr Furth had provided additional information on such difficulties at the Committee's second meeting. The Nordic delegations were very much concerned that those difficulties might increase if a target of 60% was adopted. WHO needed staff of the highest professional standards and integrity, and care must be taken not to make recruitment policy subject to any restrictions so stringent that the overall goal of always recruiting the best qualified personnel might be jeopardized. The Nordic delegations therefore supported the original proposal by the Executive Board contained in resolution EB75.R8 and were opposed to the amendments proposed by Mongolia.

Mr DE BURGER (Canada) said that to increase the target from 40% to 60%, as proposed by Mongolia, would not in itself affect the speed at which existing disparities were being corrected. As the delegate from Papua New Guinea had observed at the Committee's second meeting, the recruitment of scarce qualified staff from some countries could actually reduce the ability of those countries to meet their health service delivery needs. Consequently, WHO ought not to place them in such a situation in order to meet some quota established on grounds of equity.

The Director-General's current initiative to increase the number of women employed in the professional categories was a significant factor which must be taken into account in recruitment, since under-representation existed not only on a national, regional or sectoral basis but also on a gender basis. The issue was not one of preferential hiring but rather of equitable recruitment practices. However, quality should not be sacrificed out of a desire to be fair.

Mr VOIGTLANDER (Federal Republic of Germany) said that the report of the Director-General indicated that progress had been made in geographical representativeness overall, as borne out by the total figures. However, the figures also revealed that in some areas the situation was either unchanged or had worsened. Some under-represented Member States had already been on the list for some considerable time; his own country was in that position. While there were many reasons for that situation, attention needed to be drawn to the serious problems created when a country was under-represented by over 50% for many years. If suitable candidates were put forward, it should be possible to place greater emphasis on the degree to which their countries were unrepresented or under-represented, without disregarding the need for them to possess the necessary qualification which was the essential criterion. Therefore, while supporting in general the draft resolution recommended by the Executive Board, his delegation stressed the importance of operative paragraph 4, which called upon the Director-General and the Regional Directors to pursue energetically their efforts to continue to improve both the geographical representativeness of the staff and the proportion of posts occupied by women.

Dr NGUYEN KIM PHONG (Viet Nam) congratulated the Director-General for his efforts in recent years to improve the position regarding the appointment of nationals of unrepresented and under-represented countries. Referring to Appendix 1 of Annex 2 to document EB75/1985/REC/1 on the evolution of the geographical representativeness of the staff between October 1982 and October 1984, he asked for the position of Viet Nam to be clarified. His delegation favoured a more equitable and rational distribution of staff in WHO that would ensure geographical representativeness, and therefore supported the amendment proposed by the Mongolian delegation.

Dr YACOUB (Bahrain) said that, in recruitment for WHO, the emphasis should be on the equality, integrity, experience, knowledge and qualifications of the candidates, who should be selected on merit and not according to nationality. If the Director-General or Regional Directors had to take account of percentages, the Organization would be staffed by people unable to contribute anything, whether at local, national, regional, or headquarters level. Quality should in no way be jeopardized. In countries like Bahrain, if staff were sent to WHO, those remaining would be so few that projects would be adversely affected; that did not mean, however, that WHO should recruit from the developed countries alone.

Dr SUDSUKH (Thailand) joined in congratulating the Director-General and the Secretariat on their continued efforts towards solving the problem of geographical representativeness and increasing the proportion of women on the professional staff of the Organization. He also
agreed with the delegates of the United Kingdom, Papua New Guinea and other countries that the efficiency, competence and integrity of the candidates had also to be taken into consideration. His delegation had been convinced by the Assistant Director-General's explanation that, under Article 35 of the Constitution, the paramount consideration in the employment of the staff should be to ensure that the efficiency, integrity and internationally representative character of the Secretariat were maintained at the highest level. To that end, continuous, gradually progressive but firm and feasible strategies should be implemented, having regard to the willingness and readiness of the Member States concerned. He therefore supported the draft resolution recommended by the Executive Board in resolution EB75.R8.

Mr CAMPBELL (Australia) expressed appreciation of WHO's efforts to achieve greater geographical representativeness of its staff. However, he associated himself with previous speakers who had drawn attention to the paramount importance of the recruitment criteria outlined in Article 35 of the Constitution. For that reason he strongly supported the draft resolution recommended by the Executive Board in resolution EB75.R8.

Professor CEVIK (Turkey) welcomed the efforts made by the Director-General to improve the representativeness of international personnel in WHO, and to recruit a higher proportion of women. In developing countries, including Turkey, there had been a striking increase in the female student enrolment in the health-related sciences, and the proportion of women in the higher levels of the teaching staff of the higher educational institutes, including universities, was now almost double that of men. The need for a high level of qualifications as well as geographical representativeness must be taken into account. Believing strongly in the role and place of women in the development of the health and welfare of nations, her delegation looked forward to an increase in the rate of recruitment and number of women in the Organization.

Mrs VAN DRUNEN LITTEL (Netherlands) said that, as Annex 2 of document EB75/1985/REC/1 indicated, the Netherlands also belonged to the category of under-represented countries. Her delegation hoped that the Secretariat would use all available means to remedy that situation in the near future. Her delegation had noted with appreciation the efforts of WHO to increase the number of women on its professional staff, and looked forward to the results of the recruitment study by Dr Law. The Netherlands delegation supported the draft resolution contained in resolution EB75.R8, and opposed the amendments put forward by the Mongolian delegation.

Dr HACEN (Mauritania) said that there was at times a conflict between the need to obtain the high qualifications required to ensure the proper functioning of the Organization and an equitable staff distribution, both geographical and in terms of the proportion of women. Both requirements were equally valid. The problem could not be tackled at the purely theoretical level. How many suitably qualified candidates from under-represented or unrepresented countries had, in fact, been rejected? If there was any discrimination Member States should prove it. Only then could a useful and objective conclusion be drawn. In any event, the Mauritanian delegation appreciated the progress that had been made and hoped that even greater progress would be made in the future. It also hoped that Member States would follow the question closely, together with the Director-General, particularly when submitting candidates. The Mauritanian delegation supported the draft resolution contained in resolution EB75.R8.

Dr NYAM-OSOR (Mongolia) suggested that the Committee's consideration of the question before it should be terminated. His delegation had put forward a draft amendment in the interests of all unrepresented or under-represented countries and could not understand the views of some delegations that there might be difficulties regarding the competence of the Secretariat if a target of 60% were adopted for the recruitment of nationals of unrepresented and under-represented Member States and a 30% target for the proportion of posts to be filled by women. In the developing countries, the number of highly qualified personnel, who were familiar with the problems of their own countries, was increasing. To leave the target at 40% was tantamount to accepting that no progress would be made in eliminating the geographical anomalies that had been under discussion for many years.

The CHAIRMAN said that, since there was clearly no consensus on the amendments put forward by the Mongolian delegation, he proposed to put those amendments to the vote.
The proposed amendments were rejected by 53 votes to 16, with 22 abstentions.

The draft resolution recommended by the Executive Board in resolution EB75.8 was approved.

The DIRECTOR-GENERAL said that, in exercising his function as chief technical and administrative officer of the Organization, he was following two main guiding principles. First, the Constitution had to be strictly respected; secondly, every possible effort had to be made to obtain a consensus of WHO's membership on all issues. He sincerely believed that no international instrument could be operated dynamically on any other basis. He assured delegates that the Director-General, the Regional Directors and the Assistant Directors-General did their utmost to resolve the difficult problem of satisfying both the basic technical and managerial needs of the Organization and the diverse wishes of its membership. The situation was further complicated by the fact that views about recruitment, expressed at the regional level, were sometimes at variance with the targets imposed at the global level. In this connection he recalled that, in accordance with Article 53 of the Constitution, the staff of the regional offices was appointed by agreement between the Director-General and the Regional Directors to reflect the regionalized character of WHO.

In listing the factors to be taken into account in recruiting staff, Article 35 of the Constitution stated that "the paramount consideration in the employment of the staff shall be to assure that the efficiency, integrity and internationally representative character of the Secretariat shall be maintained at the highest level". There was a clear distinction between that provision and the following sentence, namely, that "Due regard shall be paid also to the importance of recruiting the staff on as wide a geographical basis as possible." That text clearly did not identify international representativeness with geographical distribution. For reasons that had been explained, it would be most difficult to obtain total geographical distribution, but every effort was being made to obtain international representativeness of all groups of Member States. In that connection, he noted the statements of the delegate of Bahrain and others, who explained that their national needs required them to keep qualified staff for national duties and prevented them from presenting candidates to WHO. The views of those delegates who had expressed their dissatisfaction with the degree of international representativeness of the staff would, of course, be taken into consideration within the framework of the constitutional provisions for staff recruitment but without the strict imposition of a geographical quota system, which would not be in the interest of good day-to-day management.

4. REVIEW OF THE FINANCIAL POSITION OF THE ORGANIZATION: Item 24 of the Agenda (continued from the second meeting, section 1)

Mr. GRIMSSON (representative of the Executive Board), introducing document A38/24, said that the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-eighth World Health Assembly had considered the situation of 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 (Document A38/24)

Although the total amount due from the seven Members concerned (some US$ 2 million) had had a lesser impact on the Organization's finances than the total amount due from the 49 Members which had not paid any part of their 1984 contribution (some US$ 20 million) it had been clear that, in view of the deteriorating trend, the Committee should make recommendations in accordance with operative paragraph 4 of resolution WHA37.7, reproduced in paragraph 3 of document A38/24.

As indicated in paragraphs 4 and 5 of its report, the Committee had taken account in its review of special and exceptional circumstances affecting certain Members. On that basis, and bearing in mind the position taken by the Thirty-seventh World Health Assembly in resolution WHA37.7, the Committee had decided, in view of the long-standing failure by Romania to pay its contributions, to recommend to the Health Assembly that it suspend the voting privileges of that country for the current Health Assembly.

1 Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA38.12.
It had been the understanding of the Committee to Consider Certain Financial Matters prior to the Thirty-eighth World Health Assembly, however, that prior to a final decision by Committee B, the Director-General would contact some of the countries concerned and report on the results of the discussions.

He drew the Committee's attention to the draft resolution in paragraph 6 of document A38/24.

The CHAIRMAN recalled that, as a result of the Executive Board's action, the Director-General had sent a telex on the subject to several countries asking them to respond by 8 May.

Mr FURTH (Assistant Director-General) explained that two countries had responded by providing additional information. Although payment had not yet been received by WHO from Guinea-Bissau, the Banque nationale de Paris in Paris had confirmed that it had received instructions for payment from that country and that it was transferring funds to WHO's account in the Federal Reserve Bank in New York.

Zaire had confirmed that instructions for payment had been sent to the City Bank in Zurich and to the Federal Reserve Bank in New York, both of which had WHO accounts. However, no notification had as yet been received from the banks concerned.

He suggested that the fourth preambular paragraph of the draft resolution in document A38/24 be amended to read: "Having noted that Guinea-Bissau and Zaire have indicated that arrangements for the transfer of funds are being made". The words "and Zaire" should be deleted from the sixth preambular paragraph, and the word "and" should be inserted between the words "Mauritania" and "Saint Lucia".

The Legal Counsel had advised him that if the Committee wished to vote on operative paragraph 3 the words "during the Thirty-eighth World Health Assembly" should be added.

The DIRECTOR-GENERAL announced that he had received a communication the previous day from the Ambassador of Romania, on behalf of his Government, to the effect that Romania intended in the very near future to send a delegation to WHO in order to discuss the modalities for settling its arrears of contributions. He understood that the visit was to take place within the next month or so. Romania had once again manifested its willingness to cooperate actively with WHO in all its programmes, and in particular to support developing countries, through WHO, in improving their health situation. The Ambassador had felt that, in view of that information, any suspension of Romania's voting privileges at the Thirty-eighth World Health Assembly would not be in the interest of cooperation between that country and WHO.

Mr GRIMSSON (representative of the Executive Board) said he believed that in the light of the new situation to which the Director-General had drawn attention the Executive Board would be prepared to change its intentions with regard to operative paragraph 3 of the draft resolution in document A38/24.

Dr HACEN (Mauritania) said Mauritania's situation with regard to its financial obligations to the Organization was regretted. The concern the Director-General and a number of Member States had earlier expressed was fully understood. He was grateful to the Executive Board for its flexible attitude to the predicament of countries such as his own; steps would be taken to modify the status of Mauritania's contributions in such a way that Article 7 of the Constitution need no longer be invoked.

Mr MUSHOBEKWA (Zaire) regretted that Zaire figured in the draft resolution, even though there was no suggestion that it be subject to the provisions of Article 7 of the Constitution. Although paragraph 4 of the report by the Director-General annexed to document A38/24 contained no information on any action taken by Zaire since the closure of the Thirty-seventh Health Assembly, steps had in fact been taken in advance of the meeting of the Committee of the Executive Board to transfer the full amount of its arrears (US$ 68 505) to WHO. The procedure had been completed on 7 May 1985 and payment was now in the pipeline. In view of the efforts his Government had made, he concurred with the Assistant Director-General's suggestion for the amendment of those parts of the draft resolution concerning Zaire.

Mrs WOLF (German Democratic Republic) said that as earlier speakers had emphasized, the considerable increase over the years in the number of Members in arrears in the payment of their contributions to an extent which might invoke Article 7 of the Constitution was a matter of considerable concern.
With respect to the draft resolution in document A38/24, she recalled that the Health Assembly had always decided in recent years not to suspend the voting privileges of Members in arrears; her delegation would propose that the same procedure should again be followed. That would certainly promote a spirit of mutual understanding and cooperation in the Organization.

Dr COSTA (Guinea-Bissau) expressed regret that his country figured in the draft resolution. He assured the Committee that action was under way to deal with the arrears. The Guinea-Bissau delegation had, on arrival in Geneva, provided the Secretariat with all the relevant information; he was confident that the matter would be settled well before closure of the Health Assembly.

Mr MELESCANU (Romania) thanked the Director-General for his statement concerning Romania, and confirmed that the Romanian Government had decided to despatch a delegation as soon as possible to discuss ways and means of rectifying the present difficult situation. He appreciated the Executive Board representative's endorsement of the view that under the circumstances it would not be in the interests of cooperation between Romania and WHO to suspend that country's voting rights, and welcomed the announced amendment of the draft resolution.

Mr CAO Yonglin (China) said that he sympathized greatly with the difficulties of countries in arrears. Inability to pay contributions in time was the result of economic problems brought on by untoward events such as natural disasters. It was, nevertheless, the duty of Member States to pay their contributions; the countries concerned, although the reasons for their arrears were understandable, ought therefore to make efforts to pay off those arrears gradually while developing their national economies and overcoming the difficulties facing them. He did not consider that the voting privileges of countries experiencing genuine difficulties in paying their contributions should be suspended, and hoped that the Organization would find solutions to the problem in consultation with the countries concerned. It was gratifying to hear that that procedure was in fact being followed with regard to Romania.

The CHAIRMAN proposed that, in the light of the information provided and the comments made, the suggested amendments to the draft resolution be adopted.

It was so agreed.

The draft resolution, as amended, was approved.1

5. NUMBER OF MEMBERS OF THE EXECUTIVE BOARD: Item 31 of the Agenda (Documents EB75/1985/REC/1, resolution EB75.R4, and A38/92)

Dr HAPSARA (representative of the Executive Board), introducing the item, said that during the discussion of the report of the Regional Director for the Western Pacific, the Executive Board had taken note of resolution WPR/RC35.R10 in which the Regional Committee had recommended to the Executive Board, and through it to the Health Assembly, that consideration be given to increasing the number of Members from the Western Pacific Region entitled to designate a member of the Board from three to four, on account of the size of the population of the Region. A draft resolution had been submitted to the Board recommending to the Thirty-eighth World Health Assembly that it consider increasing the membership of the Executive Board from 31 to 32.

During its discussion the Executive Board had considered the criteria used hitherto for selecting members of the Board and had taken note of the information supplied to it on the subject by the Secretariat. It had been stressed, however, that the resolution submitted did not constitute an amendment to the Constitution but was merely intended to draw the Health Assembly's attention to the problem. The resolution had been adopted unopposed.

The CHAIRMAN drew attention to a draft resolution sponsored by the delegations of Australia, China, Japan, Kiribati, Malaysia, New Zealand, Philippines, Republic of Korea and Tonga, which read as follows:

1 Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA38.13.
The Thirty-eighth World Health Assembly,

Having considered resolution EB75.R4 of the Executive Board and resolution WPR/RC35.10 of the thirty-fifth session of the Regional Committee for the Western Pacific;

Recognizing the need to increase the number of Members from the Western Pacific Region entitled to designate a person to serve on the Executive Board from the current three to four, taking into account the recent increase in the number of Members in the Region and the size of its population;

REQUESTS the Director-General to propose for the consideration of the Thirty-ninth World Health Assembly draft amendments to the Constitution in order to increase the membership of the Executive Board from 31 to 32, so that the number of Members of the Western Pacific Region entitled to designate a person to serve on the Executive Board be increased to four, and to transmit such draft amendments to Members at least six months in advance of their consideration in accordance with the provision of Article 73 of the Constitution.

Dr KITAGAWA (Japan) said that Japan fully supported the draft resolution. It was undeniable that the Regional Committee for the Western Pacific had been making a considerable contribution to WHO activities not merely in the region concerned but in their entirety. The Western Pacific Region, which was both vast and populous, had been playing an increasingly important role in WHO activities in each succeeding year. The number of Member States in the Region had also been growing with the recent entry of newly formed island States in the Pacific. However, the Western Pacific Region with three seats had the smallest representation of all the regions on the Executive Board. That — he submitted — was unreasonable; the Executive Board was a governing body of such importance in WHO’s structure that the Western Pacific Region had every reason to expect equitable representation on it.

A plea was not being made for wholesale changes in the present structure of the Executive Board nor for drawing up new criteria for membership. Still less was it wished to waste time in polemical discussion. What was urged was that a decision be taken as soon as possible to rectify what was a clear case of imbalance. The Executive Board itself, at its seventy-fifth session, had in fact unanimously adopted a resolution recommending to the Health Assembly that it consider increasing the membership of the Executive Board from 31 to 32, the extra seat to go to the Western Pacific Region in view of the recent increase in the number of Members in the Region and the size of its population. Committee B should follow up that realistic proposal by taking a further step in the direction of prompt settlement of the matter.

Mr Jong Koo AHN (Republic of Korea), speaking as a co-sponsor of the draft resolution, supported the views expressed by the delegate of Japan and called for favourable consideration of the draft resolution.

Dr KHALID BIN SAHAN (Malaysia) said that he had supported the proposal both in the Regional Committee and in the Executive Board and would continue to do so in the Committee. It was justified by the number of Member States in the Region concerned and by the overall size of its population (approximately 30% of the world population). Furthermore, the Western Pacific was the most heterogeneous of all WHO’s regions, with many of its countries at different extremes of size, level of development, economic characteristic and climate. Increasing its representation on the Executive Board would also be in the spirit of equitable distribution mentioned in Article 24 of the Constitution and would be in line with the functions of the Board as laid down in Article 28. It would take account of the heterogeneity to which he had referred, and enable the Member States of the Region to play a more active part in the affairs of the Board and thus of the Organization.

In supporting the proposal he was not unmindful of the need to keep the size of the Board within workable limits. Nor was he unmindful of the fact that Board members were the representatives of their regions and not of their countries. However, the 1976 constitutional amendment that had increased Executive Board membership from 30 to 31 had been based on considerations of number of Member States and population. He would submit that analogous conditions now existing in the Western Pacific justified a similar increase.

Dr BURKE (Belgium) said that the co-sponsors of the draft resolution had advanced a number of pertinent arguments. Other aspects of the question ought, however, to be taken into account, such as the principle of proportionality, based on numbers of Member States,
and above all, the need to hold Board membership at a reasonable figure in order to permit effective functioning. Those reservations having been made, however, he was not unconditionally opposed to the draft resolution.

Mrs NASCIMBENE DE DUMONT (Argentina) said the reasons for the proposal were understandable; her delegation was fully in sympathy with the desire of the countries of the Western Pacific Region to have an additional representative on the Board to bring its representation more into line with the other regions. However, Argentina considered that the Board, in view of its nature and functions, should be a body with limited membership. In 1984, in application of the 1976 constitutional amendment, Board membership had been increased by one. Now, only one year later, there was a proposal for a further increase. That was not a move in the right direction; the valid aspirations of the countries of the Western Pacific Regions would, she believed, be better satisfied by a redistribution of the existing seats on the Board.

Dr SUDSUHK (Thailand) said that since the Executive Board played a crucial role in ensuring the healthy development and advancement of the Organization, it was important to ensure appropriate representation in that body so that Members might fulfil their functions effectively. He entirely agreed with the recently modified criterion for selection, which took account both of the number of Member States of the region concerned and of the size of its population. That criterion had already been applied in the case of the South-East Asia Region; it was now appropriate to extend it to the Western Pacific Region by increasing the number of Members entitled to designate a person to serve on the Board from three to four, the total membership of the Board being increased to 32.

Dr TAPA (Tonga), speaking as one of the sponsors of the draft resolution, said that before the Regional Committee for the Western Pacific had urged enlargement of Board membership in September 1984, an earlier resolution to the same effect had been adopted at the Committee's thirty-second session in September 1981. On the first of those occasions, the grounds for the request had been that the Western Pacific Region had the highest population of any WHO region; by 1984, there had been the additional justification that the number of Member States of the Region had increased to 19. There were therefore even stronger arguments at the present time for supporting the request made in the draft resolution for an increase in the number of members of the Executive Board.

Mr BROCHARD (France) said that all were aware of the fact that the number of Member States of the Western Pacific Region had increased in recent years, and that due account should be taken of the size of population of the Region. It was therefore out of the concern for balance and equity that his delegation supported the proposal before the Committee, which he hoped would be adopted by consensus, as it had been by the Executive Board at its seventy-fifth session.

Mr CAMPBELL (Australia) associated himself with earlier comments in support of the draft resolution. During the past three years, five new countries (Vanuatu, Solomon Islands, Kiribati, Cook Islands and Brunei Darussalam) had joined the Western Pacific Region, thus increasing the theoretical number of seats, based on the ratio of Member States to seats allocated, from 3.1 to 3.8. Although some 40% of the world's population lived in the Western Pacific Region, that Region was represented by only 10% of the seats on the Executive Board. In view of that inequity, the Board had decided by 21 votes to none at its seventy-fifth session to recommend that the Health Assembly consider increasing the membership of the Executive Board from 31 to 32. He urged the Committee to support the draft resolution.

Dr QUAMINA (Trinidad and Tobago) said that she had been impressed by the arguments put forward. She, too, supported the draft resolution.

Mr CAO Yonglin (China) said that the Constitution of WHO clearly stated that the composition of the Executive Board should reflect the principle of equitable geographic distribution. There had recently been a significant increase in the number of Member States from the Western Pacific Region, and that trend would probably continue. Furthermore, the Western Pacific Region had one of the largest populations of any of the WHO regions. The Member States concerned made a valuable contribution to the work of the Organization, in particular through their efforts to achieve the goal of health for all, and they should have the opportunity of greater participation in WHO activities, notably in those of the Board, which was one of the Organization's chief deliberating bodies. He too urged adoption of the draft resolution.
Miss RIDDELL (New Zealand) joined in supporting the draft resolution.

Mr BOYER (United States of America) agreed that seats on the Board should be distributed appropriately, and sympathized with the wish of Member States in the Western Pacific Region to have larger representation in keeping with their growing numbers. However, a decision to enlarge the Board should not be taken lightly. The Board performed a valuable task in helping to prepare for the Assembly; if it were to fulfil that task effectively, its membership should be kept reasonably small. The experience of other United Nations agencies with much larger Executive Boards had been that large numbers made such bodies unwieldy and difficult to operate. He pointed out that WHO's own Executive Board had established a Programme Committee consisting of only nine members because it had considered it useful for a smaller body to conduct part of its business.

Although he would not challenge the draft resolution, he wished to register his concern that WHO's Executive Board should not become too large to be effective.

The CHAIRMAN said that the concern expressed by the United States delegate would be reflected in the summary record.

The draft resolution was approved.¹

The meeting rose at 16h55.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA38.14.
FOURTH MEETING

Monday, 13 May 1985, at 14h30

Chairman: Mr R. ROCHON (Canada)

1. ORGANIZATION OF WORK

The CHAIRMAN expressed his satisfaction that the Committee had, during its first week of work, paid heed to the President's request in his opening address and had not spent precious time on extraneous political issues. As the Committee entered its second week of work, he would draw its attention further to the President's additional statement, made at the beginning of the eleventh plenary meeting, expressing support for the appeal made by the Director-General in his concluding remarks at the end of the general debate and urging delegations once more to keep extraneous political considerations, which were better dealt with in other forums of the United Nations system, out of the deliberations of an assembly which was accustomed to deciding health goals and strategies in total unanimity; that would give health its proper place as a powerful platform for peace and harmony in a troubled world.

2. HEALTH CONDITIONS OF THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE: Item 32 of the Agenda (Resolution WHA37.26; Documents A38/10 and A38/INF.DOC./6, 8, 9 and 9 Corr.1)

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 A38/10), and the report of the Ministry of Health of Israel (document A38/INF.DOC./6), the abridged report of the Director of Health of UNRWA (document A38/INF.DOC./8) and the report of the Palestine Liberation Organization (document A38/INF.DOC./9) - the following draft resolution sponsored by the delegations of Afghanistan, Algeria, Angola, Bahrain, China, Cuba, Democratic People's Republic of Korea, Democratic Yemen, Djibouti, India, Indonesia, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Malaysia, Maldives, Malta, Mauritania, Morocco, Mozambique, Nicaragua, Oman, Pakistan, Qatar, Saudi Arabia, Senegal, Seychelles, Solomon Islands, Somalia, Syrian Arab Republic, Tunisia, United Arab Emirates, Vanuatu, Viet Nam, Yemen and Yugoslavia:

The Thirty-eighth World Health Assembly,
Mindful of the basic principle established in the WHO Constitution, which affirms that the health of all peoples is fundamental to the attainment of peace and security;
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 has serious repercussions on the health and psychosocial conditions of the people under occupation, including mental and physical health, 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 39/49, 39/95 and 39/169 as well as 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 for 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, and through their institutions, the provision of their own health and social services;

1. **REAFFIRMS** resolutions WHA37.26, WHA36.27 and previous relevant resolutions of the World Health Assembly;

2. **CONDEMNS** Israel for its continuing occupation of Arab territories, its arbitrary practices against the Arab population, and its continuing establishment of Israeli settlements in the occupied Arab territories, including Palestine and the Golan; and for its 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, all of which have devastating and long term effects on the mental and physical health conditions of the population under occupation;

3. **CONDEMNS** Israel for its policy aiming at making the population of the occupied Arab territories, including Palestine and the Golan, dependent on the Israeli health system, by hindering the normal development of the Arab health institutions, as part of Israel’s overall plan of annexation of those territories;

4. **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;

5. **DEMANDS** an immediate end to occupation, violence and repression, and to the establishment of new settlements; also demands that those settlements already established be dismantled, in order to enable the Palestinian people to exercise its inalienable national rights, as a prerequisite to the establishment of a social and health system that would be able to ensure health for all by the year 2000;

6. **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-ninth World Health Assembly;

7. **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 help the Palestinian people and their health institutions to promote primary health care inside and outside the occupied Palestinian territories, by developing sufficient health and social services, and by the training of additional health personnel, in order to reach health for all by the year 2000;
   (3) to monitor the health conditions of the Arab population in the occupied Arab territories, including Palestine, and report regularly to the Health Assembly;

8. **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 physical and psychological health of the Arab inhabitants in the occupied Arab territories, including Palestine, and to report to the Thirty-ninth 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 A38/10), its seventh since 1978. In the course of its annual visits to the occupied territories, the Committee had looked into a wide range of health problems, which it had reported on to the Health Assembly. Those problems and the methodologies used to investigate them had been selected on the basis of technical documents prepared by the Organization, and all the reports had included recommendations based on the Committee's observations.

In all its reports the Committee's primary aim had been plainly and objectively to record the facts. However, bearing in mind the definition of health adopted by the World Health Organization, it had also consistently stressed that it would be wrong automatically to equate an improvement in given services or an increase in health care delivery with the actual health status of a population. While it would be absurd to claim that such improvements failed to have a positive effect on persons with disease, who were treated by the services concerned, the existence of those services did not and could not have an impact on the health status of the community as a whole, which was mainly determined by the social and economic conditions under which it lived. As long as the problem of the occupied territories remained unsolved in political terms, reference to the health status of the population in the sense accepted by the Organization was impossible, and the Organization would continue to be confronted with contradictory information; such a situation was not conducive to the creation of the atmosphere required to generate international cooperative action.

The Committee's report drew attention to the fact that as long as the existing situation prevailed, two opinions would exist on every problem, since differing initial premises led inevitably to contradictory and incompatible information. Under normal circumstances, the solution of one practical problem in a system such as a health system, would help in solving other problems in the same system, leading to a long-term improvement in its overall performance. In the occupied territories, however, the very fact of foreign occupation precluded the solution found for one given problem from helping to solve the problems of the system as a whole. That explained the paradox that the sophistication of the health services in the occupied territories, although it might solve some practical problems, ran the long-term risk of binding the health services of the occupied territories to the Israeli health services as a subordinate system. Health problems in the occupied territories always had a political connotation, and that, perhaps, explained why some specialists living in those territories held conflicting opinions on the aims and the role of the Special Committee. The solution of the medical and other problems affecting the people in the occupied territories depended on a solution being found to the political issue.

In conclusion, he expressed the Special Committee's thanks to all the governmental and local authorities, organizations and individuals who had helped it to accomplish its task, and its particular gratitude to the Director-General and the WHO Secretariat for the support they had given the Committee throughout its work.

Dr HIDDLESTONE (Director of Health, United Nations Relief and Works Agency for Palestine 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 35 years of service to the Palestine refugees, had relied almost entirely on voluntary contributions (primarily from governments) 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. That, coupled with population increases, had made it increasingly difficult for the Agency to cover its budget needs. The Agency's limited reserves had all been mobilized and contributions had fallen at a time when responsibilities were increasing.

The year 1984 had been a period of serious testing of UNRWA's ability to meet the extent of its mandate and consequent responsibilities. The continued sectarian fighting coupled with the hostilities in Lebanon had compounded the problem of resources. By decision of the Commissioner-General, UNRWA's help had continued to all distressed Palestinians in Lebanon, whether or not they were registered with the Agency. Many had been dispossessed of homes, family support and what few possessions they had. Their needs could only be supplied by total commitment of all resources. Again, within the Agency's regular health care programme, new needs had come to light: diabetes, the needs of the elderly, stunting of children's growth, widespread nutritional anaemia. All required investigation and urgent attention. Thus the Agency's health services could not be curtailed; in fact they represented remarkable value, a modest budget of US$ 40 million serving a needy population of
nearly two million people. In per capita terms, that allocation was extraordinarily low by any international standard; it should also be remembered that the refugee population concerned stood in greater need than most people elsewhere in the world. The allocation could only be pared down by reducing essential services; yet the Agency faced the current year of 1985 with reduced contributions in cash and kind. The hapless lot of Palestinian refugees could only be aggravated by the lessening response of the international community. He appealed to all delegates to think again of the Palestinian refugees, for whose care UNRWA had received a mandate from the United Nations General Assembly, and, in the spirit of cooperation that should be a constant spur to all health workers and administrators, to draw the attention of their governments to the present state of affairs, asking them to consider UNRWA's need for increased donations sympathetically.

The abridged version of the annual report of the Director of Health of UNRWA for 1984 (document A38/INF.DOC./8) 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 fact that the report should be read as UNRWA's response to the challenge of health for all by the year 2000. The Regional Director for Europe had suggested six major themes to inspire the health-for-all strategy: namely, that health implied equity; that people must be given a positive sense of health; that a key element was a well-informed, well-motivated and actively participating community; that cooperation should be multisectoral; that emphasis should be placed on primary health care; and that there should be international cooperation as health problems transcended national frontiers. Those themes, and variations upon them, seemed an excellent checklist against which to review the UNRWA health endeavour for the past year. Presentation of the report was no mere formality but rather an account of WHO's realistic concern and support for the Palestine refugees scattered over five geographical areas, for the care of whom UNRWA had been given a mandate renewed each year for the last 35 years. The report recorded a continued caring activity overlaid by new efforts to meet new challenges.

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 the health of the Palestinian 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 was grateful to all those organizations for their valuable assistance and to the ministries of health in the fields of operation for their close and fruitful cooperation with the Agency, which had made possible the execution of its task.

The DIRECTOR-GENERAL said that WHO was continuing to play an active role in providing assistance to the Palestinian people, and in 1984 had participated in both the meeting convened by the United Nations on Assistance to the Palestinian People, and in the African Regional Seminar on the Exercise of the Inalienable Rights of the Palestinian People. As the Director of Health of UNRWA had indicated, close collaboration had been maintained with the Agency, particularly in the fields of child health, diarrhoeal diseases control, immunization and environmental health. The Organization had provided a consultant on the control of diarrhoeal diseases, who, together with UNRWA staff, had carried out two training courses for physicians and nurses serving the Palestinian people. WHO staff and a short-term consultant had also assisted in a one-month course for UNRWA staff on food supervision and nutrition held in Amman in 1984. Fellowships had been awarded for the training of physicians and nurses in such areas as maternal and child health, public health administration and clinical and tropical medicine. Achievements in the control of communicable diseases were reflected in the fact that Palestinians were now living in malaria-free areas, assistance in that field no longer being required. To follow up a request concerning the immunization of Palestinian women against German measles, vaccines and diagnostic kits had been provided. As part of WHO's efforts to foster a comprehensive system of health care for the population concerned, the Organization was supporting the development of basic radiological services for better radiological coverage. One radiological machine had already been installed in the Beqaa Valley Health Centre and a second would be provided for the Bureij tuberculosis hospital in Gaza.

Since his report on the subject to the Thirty-seventh World Health Assembly, there had been steady progress in the development of health centres in the occupied territories. Two were now formally designated as WHO collaborating centres in primary health care research; work was already under way at the first, the Health Services Research Centre in Ramallah. In
all WHO's work there and in the territories in general, the Organization was pleased to have had the close collaboration of UNDP and its Programme of Assistance to the Palestinian People. While the full responsibility for technical supervision of the primary health care research work which was to be undertaken at each centre would clearly rest with WHO, UNDP had agreed to assume responsibility for administrative management of the centres on the basis of an agreement concluded between UNDP and WHO early in 1984. In both cases, the overall objective of the work would be to support the undertaking of health systems research aimed at ensuring total coverage of the local population with primary health care, using the most appropriate technology.

At Ramallah, where specific research projects were at present getting under way, projects would include: an evaluation of a plan for expanded primary health care in the villages of the area; evaluative studies of the practices and outcomes of the work of traditional birth attendants as a component of primary health care; continuation of previous studies of growth and development of infants and children; evaluative studies on the effects of the intensive programme of immunization against tetanus neonatorum and adult tetanus; evaluation of the routine immunization programme for the prevention of rubella; a study to assess the utilization and impact of oral rehydration therapy in primary health care and in hospital centres; basic epidemiological studies of acute respiratory diseases, and further studies related to the prevalence of lead intoxication in a number of villages in the area, the epidemiology of hepatitis and of brucellosis, and nutrition, breast-feeding and anaemia. The costs of WHO support to those activities alone would amount to more than US$ 200 000.

The second centre to be designated as a WHO collaborating centre was the Epidemiology and Health Information Centre of the Health Services of Gaza. Here, a costed workplan to enable specific activities to get under way was expected to be presented to the authorities concerned, again in close collaboration with UNDP, in the very near future. At the same time, it was confidently anticipated that a third centre, whose focus would primarily be on health manpower research in relation to primary health care, would shortly be designated.

He was confident that progress would continue in a satisfactory way, and that the approach taken, that of health systems research and development with ultimate aim of total coverage of the total population with primary health care, was the soundest approach that could be taken under the circumstances. It was gratifying to note the enthusiastic attitude to the work on the part of all those most directly concerned and he reiterated the pleasure staff of the Organization experienced working on the matter in such close partnership with UNDP.

Professor MICHAELI (Israel) said that, having been appointed to the position of Director-General of the Ministry of Health of Israel only a few months previously, he had the advantage of looking with a fresh eye at the matters under discussion. As he reviewed the health situation in Judea, Samaria and Gaza he noted the clear evidence of progress and improvement in all facets of health; in the development of the infrastructure of health services at primary health care level, in hospitals providing secondary-level care, and also, to some extent, in care services at tertiary level. In his professional opinion the health situation in the territories had been improving steadily and substantially since 1968, and in many aspects was much better than that in several neighbouring countries and in many countries elsewhere in the world. He therefore saw no justification, from the view of the health profession, for supervision or visits by a Committee.

However, in view of Israel's lengthy record of close cooperation with WHO, and in response to the Director-General's appeal, a group of experts had been invited to visit Judea, Samaria and Gaza in order to see what it had achieved in the health field and confirm once more the self-evident fact that, in the field of health, Israel was among the developed countries of the world. Developments in health services, as everyone knew, were not achieved in spurts but rather by a continuous steady progression. It was therefore impossible to observe major changes in a period of one year. The Special Committee had itself alluded in its report to the possibility that there might be no need for annual visits. The time saved in that way would be more usefully devoted to comparative studies of health in neighbouring countries, thus enabling a more balanced and objective description of the situation to be reached.

The attention of delegates was drawn to the report of the Israeli Ministry of Health (document A38/INF.DOC./6), which provided a detailed description of the health situation in Judea, Samaria and Gaza. To give some examples of the progress achieved so far: deliveries in hospitals and medical centres had increased from 13.5% to 53% in Judea and Samaria in 1984, in Gaza the increase had been from 10% to 72% in 1983; infant mortality in Judea and Samaria had declined from more than 80 per 1000 to 29 per 1000 in 1983; in Gaza, where it had been estimated at 120 per 1000 in 1968, it was at present 38 per 1000; and diseases such as poliomyelitis, diphtheria and tetanus which used to ravage the infant population in the
area were at present practically under control, and others like measles and pertussis were declining rapidly.

Such impressive achievements had been possible only through long-term investments in resources and effort. They had necessitated a 90% immunization coverage in infancy, with reinforcement at school age, together with numerous projects in health manpower training, supervision and construction of the necessary infrastructure. Such projects included the expanded primary health care project in the Hebron area and the new Health Services Research Centre in Ramallah, both with WHO and UNICEF assistance.

The Special Committee had stated that the ideal goal of complete mental, social and physical wellbeing had not yet been achieved in Judea, Samaria or Gaza. It had not yet been arrived at in Israel itself, and that was probably true of other countries, including those which regularly made scurrilous statements unworthy of WHO. Indeed, had any country truly reached that goal?

He had had a sufficiently long experience of clinical medicine, infectious diseases and public health administration to be able to evaluate the report of the Special Committee of Experts realistically and practically, and to accept many of its pertinent points. Some of its remarks, however, were only vague generalizations or were incorrect.

The statement concerning mental health (section 3.2.2) was unfounded and possibly misleading. An increase in referrals might simply reflect an increase in available services. The social conditions in the territories had changed dramatically. Rapid industrialization and modernization, improved living standards and greater freedom of women in the family and in society were responsible for the unbalanced behaviour observed in many people, especially adolescents, particularly in areas that had been exposed to such changes more rapidly than neighbouring countries which had maintained their traditional social structure and habits.

There was an error in the information given on the problem of health insurance. Such insurance covered dependants of insured households up to the age of 18, not 16, and parents over the age of 60. His delegation nevertheless accepted the Special Committee's suggestion concerning universal health insurance.

His Government had now secured funds for the Khan Younis Hospital, with financial help from various sources. In view of the deep economic crisis and the reduced financial resources available, his Government would welcome appropriate donations of that kind. He had recently received the report of a joint planning committee on health services in Judea and Samaria, following long study by a group of distinguished Arab and Jewish experts from the health services in Judea and Samaria, to which personalities representing international philanthropic organizations providing health services in the area had contributed. The document in question constituted a basic long-term plan for the future promotion of health services with respect to primary health care and preventive medicine, environmental sanitation, hospital services, budgeting and health insurance, manpower development and training, and organization of health services. It was based on an evaluation of the needs of the population in Judea and Samaria in 1990, which in turn was based on demographic trends, access to health care, the epidemiological situation, available health service needs and current international planning criteria. He hoped that the projects included in that report would be supported by WHO and other agencies that could help to finance the implementation of the plan.

He hoped that all concerned would concentrate on the task of providing health services and would refrain from bringing political difficulties into the debates. The enormous problems with which they were faced should not be exacerbated by the use of obnoxious jargon in abusive and irresponsible resolutions or statements.

As a new delegate, he was optimistic enough to hope that it would be possible to concentrate on professional debates designed to alleviate the sufferings of hundreds of thousands of victims of famine and disease through such projects as those recently carried out by his country to help men, women and children in drought-stricken areas of Africa. Refugees should be offered shelter, and camps and centres for relief and medical care should be provided in Africa. Purely political issues that led to no improvement in the health status of peoples should be avoided.

Rabbi Moses Ben Maimon, known as Maimonides, whose 850th anniversary was being commemorated, had been a physician who practised and wrote in both Arabic and Hebrew, teaching universalist values that could still honour the human community. He, the speaker, had himself taken that physician's oath at the start of his career. He urged all concerned to honour and adhere to that oath, to return to the basic task of caring for mankind, and to avoid irrelevant political deviation that could undermine the efforts to achieve the goal of health of all by the year 2000.

Mr DE MAIO (Italy), speaking on behalf of the 10 members of the European Economic Community, said that the members of the Community, which had carefully considered the report
of the Special Committee of Experts, continued to be sensitive to the sufferings caused by the situation obtaining in the occupied territories. They also considered, however, that the World Health Assembly was a technical forum in which attempts to find solutions to political problems were inappropriate. The members of the Community once again appreciated the work of the Special Committee, which was being performed in difficult circumstances. They had taken due note of the assessment — in both its favourable and unfavourable aspects — of the health system developed in the occupied territories, together with the report's conclusions, including the reference to the periodicity of the Special Committee's visits.

The report referred, for example, to excessive dependency with respect to referral to Israeli hospitals of patients needing special care. The members of the Community hoped that the peoples concerned would be more broadly associated with the management of health programmes and budgets, particularly in the Gaza area. They had taken note of the efforts made to improve health services on the West Bank and to promote environmental sanitation, and hoped those efforts would be continued. They were aware that health assistance in the territories was being provided in exceptional circumstances, and they considered it essential that the greatest possible attention be devoted to the requirements of the local population.

The 10 members of the 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.

Mr TAWFIQ (Kuwait) welcomed the Director-General's efforts to improve the health conditions of the Arab population in the occupied Arab territories, including Palestine, and to implement the various Health Assembly resolutions on the subject. Special mention should be made of the action taken to establish the three medical centres on the West Bank and in the Gaza area, in accordance with resolutions WHA36.27 and WHA37.26. Despite the obstacles raised by the Israeli authorities, he was convinced that those resolutions could be fully implemented. The Special Committee of Experts had tackled its difficult task with seriousness and integrity and had produced a valuable report.

On a procedural matter, he observed that the Secretariat had circulated a report submitted by the delegation of Israel, the covering letter to which made a reference to Judea and Samaria. Item 32 of the agenda, under which the Secretariat had circulated the report, referred to no such place names. The Secretariat should take care in future not to circulate reports whose subject matter failed to conform to the agenda item concerned. To do so was at variance with the procedural requirements for the circulation of documents. Judea and Samaria were not accepted place names and to use such names was contrary to the provisions of humanitarian law, the relevant international instruments and international practice, which prohibited an occupying power from changing geographical names in occupied territories. The report should be declared null and void. He would like to hear the opinion of the Director-General and the Legal Counsel on the matter.

Whenever the question of the health conditions of the Arab population in the occupied Arab territories, including Palestine, was considered, the Israeli delegation launched into tendentious and unfounded allegations in order to divert attention from the true situation. Delegates were aware of the despotic and tyrannical acts committed by Israel, which had resorted to torture, destruction of dwellings, desecration of holy places, detention, persecution and explosion, and had massacred the innocent and peace-loving people of Sabra and Shatila. Its acts of unprecedented barbarism in Lebanon would never be forgotten.

Israel had been unmasked and condemned in the report of the Special Committee of Experts. The second paragraph of section 3 of that report stated that, whatever observations the Committee had made concerning the health conditions in the occupied territories, the problem of the population's health in the sense of the WHO definition could be resolved only as a result of political action, for there could be no health without peace, liberty and justice.

The World Health Assembly had expressed its sympathy with the population concerned. In view of the deterioration in the health status of that population, the relevant Health Assembly resolutions represented the minimum that could be adopted.

He appealed to the Committee to support the latest draft resolution, which its sponsors, as representatives of peace-loving countries, considered as the very least that could be done for the Palestinian people, who were struggling to regain their dignity and restore their rights.

The Special Committee of Experts must continue to visit the occupied Arab territories annually to enable the Health Assembly to make its annual review on the basis of that Committee's report. He urged delegations to support the efforts being made to provide the population concerned with the necessary health care, without which the noble objective of health for all by the year 2000 could not be attained.
Dr ARAFAT (Palestine Liberation Organization), speaking at the invitation of the CHAIRMAN, thanked the Director-General and the members of the Special Committee of Experts for all their efforts. Every country needed a health programme for its population, but after 18 years of Israeli occupation on the West Bank and in Gaza, the Palestinian people still had nothing even vaguely resembling one.

In its report (document A38/10, section 2.3.2), the Special Committee of Experts referred to joint planning committees established in Gaza and on the West Bank but expressed serious doubts about their efficiency in so far as they were not involved in the management of the budget and did not even know the programme budget planning figure. Indeed, the only explanation for the Israeli refusal to publish the figure, as the Committee had repeatedly requested, must be that it was so small it would leave the authorities open to sharp criticism. The salaries offered to local personnel also adversely affected the health situation of the population and, as the report stated (section 2.2), there was no point in developing health systems to the utmost when personnel in sufficient numbers and of sufficient quality was unavailable.

In Gaza, the surgical section of the Khan Younis Hospital had been closed and severe restrictions were being placed on the expansion of the Sheesa Hospital, while the French Hospital in Bethlehem was to be converted into a geriatric centre. The only positive note in the report was the approval by the Israeli authorities of two projects for the construction of hospitals, but the question arose as to why they had not authorized their construction earlier.

In section 2.3.1, the report drew attention to the difficulties involved in establishing an effective hospital referral system due to the insistence of the Israeli authorities that the principal hospitals remain Israeli. The cost of insurance had increased to US$ 15 which, the Committee noted (section 3.5), was a great deal in terms of the wages paid. The drinking-water problem was becoming increasingly intense on the West Bank and in Gaza, and as a result, there was a growing incidence of morbidity from gastrointestinal infections and hepatitis. PLO was also greatly concerned about evidence of an increase in mental disease among the population of the occupied territories which the Special Committee judged to be a direct result of the occupation itself.

The PLO delegation fully concurred with the Special Committee's conclusion that the problem of the population's health in the sense of the WHO definition could be resolved only as a result of political action, for there could be no health without peace, liberty, and justice. The Special Committee acted as a mirror of the sufferings of the Palestine people and must be enabled to pursue its activities through, inter alia, the adoption of the draft resolution to which the Chairman had referred. In conclusion, he concurred with the procedure point raised by the delegate of Kuwait.

Mr VIGNES (Legal Counsel), replying to the comment made by the delegate of Kuwait, said that document A38/INF.DOC./6 had been distributed in accordance with well-established United Nations practice and Rule 18 of the Rules of Procedure of the World Health Assembly. The Director-General had determined that the relevant agenda item was item 32, even though the document did not employ the terminology normally used in United Nations documents on the subject. It was generally recognized throughout the United Nations system that the Secretariat was in no way responsible for the wording, or associated with the views expressed, in documents circulated at the request of Member States.

Mr DOWEK (Israel), speaking on a point of order, requested clarification on the extent to which the title of agenda item 32 itself corresponded to "terminology normally used", and on the geographical areas referred to.

Mr TAWFIQ (Kuwait), speaking on a point of order, said that if the Secretariat could certainly not be held responsible for the contents of documents it distributed, the Director-General should make every effort to ensure that the title of a document corresponded to the agenda item under which it was circulated. If it did not, the document should be distributed without reference to a specific agenda item.

Mr VIGNES (Legal Counsel) said that the title of agenda item 32 had been established by the Health Assembly itself. Furthermore, a geographical definition of the occupied territories was a matter within the responsibilities of the competent United Nations bodies, rather than the Director-General of WHO.

Dr HACEN (Mauritania) noted, among other things, from the report of the Special Committee of Experts that in the Golan Heights the health system had been officially integrated in the Israeli health system; that, in the case of certain preventive and
curative services, there had already been a marked shift towards such integration; and that there was constant dependence on Israeli medical assistance. He further noted that the staff required for the maintenance of premises and equipment was in extremely short supply on account of the low salaries paid to them, while the health budget planning figure had not been disclosed to the Committee despite repeated requests to the West Bank authorities.

Against that background, it had become clear to the Special Committee that, whatever observations it had made concerning the health conditions in the occupied territories, the problem of the population's health in the sense of the WHO definition could be resolved only as a result of political action, for there could be no health without peace, liberty and justice.

He expressed appreciation to the Special Committee of Experts for what was altogether a most pertinent report, and thanked the Director-General for his concrete support to the populations concerned.

On the other hand, the report circulated on behalf of the Ministry of Health of Israel - and he would stress its origin - painted a gloomy picture as far as the evolution of certain infectious diseases was concerned. Table 46 in the Appendix to that report (document A38/INF.DOC./6) showed, for example, little decline between 1968 and 1984 in the incidence of measles and pertussis, but a significant increase in the number of cases of dysentery, paratyphoid and typhoid, of meningitis and of infectious hepatitis - to quote just a few examples. Indeed, he would submit that any improvement in the health situation in the occupied territories was above all the result of constant international concern, especially on the part of WHO; such vigilance must not be relaxed.

Before the Israeli occupation, the Palestinian people had already enjoyed a very high standard of health in comparison with other Arab peoples: to make such a comparison today was thus to obscure the issue. And although certain media with a colonialist slant - South African radio, for example - tried to justify domination imposed on the grounds of improvements effected, the latter were not proven and the former remained unjustifiable.

He would willingly join in paying tribute to the memory of Maimonides; but would that great scholar have remained silent in the face of occupation, terror and violent repression, with all their consequences for the health of the population concerned? And as regards physicians' oaths, was it not as important to do no harm, as to do good?

Dr Al-JABARTY (Saudi Arabia) noted that in the report circulated on its behalf (document A38/INF.DOC./6), the Ministry of Health of Israel saw fit to make statistical comparisons with other countries. He wished to point out most emphatically that the figures quoted were inexact, especially where Saudi Arabia was concerned. His delegation had submitted a document on health conditions in that country to the Secretariat, and he would not therefore go into further detail.

It had been claimed that WHO, as a specialized agency of the United Nations system, should not discuss political issues, in order to prevent the politicization of the Organization. Specialized agencies should however be wise enough to recognize when political issues must be faced; otherwise it might prove impossible to achieve their own narrower, specific objectives. It might thus be asked how it would be possible to handle problems relating to health without investigating the political conditions which had produced the problems in the first place. A specialized agency must be brave enough to shoulder its responsibilities, and not run away from discussing political issues when such discussion was essential.

In its report, the Ministry of Health of Israel had attempted to give the impression that the occupying authorities had the power to manage the affairs of the occupied territories by themselves. Such an approach was no less than a legacy of old-fashioned colonialism. Every people surely had the right to manage, or mismanage, its own affairs: that was an essential element in self-determination. That basic fact must be borne in mind in discussing the health conditions of the Arab population in any of the occupied territories. Israel was refusing to accept the basic principles of international law and moreover was breaching the Geneva Convention in its administration of the Arab territories.

The right of the Palestinian people to manage its own affairs in the field of health was clear. Full implementation of primary health care would encourage the community to assume greater responsibility in the field of health. That condition could not however be met under occupation. His delegation therefore gave its full support to the draft resolution presented by the Chairman at the beginning of the meeting.

Mr CHAUHAN (India) welcomed the clear and unbiased report prepared by the Special Committee of Experts. During the debate on the item in past years many delegations had spoken of the inalienable rights of the Arab people of the occupied territories to self-determination, to the establishment of their own independent State and to peace, freedom
and justice; objections had however been raised by some countries which had challenged the legal right of WHO to discuss what, in their opinion, was a purely political issue. The annual reports of the Special Committee of Experts had, year after year, brought out clearly how Israel's occupation of the Arab territories had stifled the development of a health infrastructure, had led to the deterioration of the hospitals of the West Bank, had prejudiced programmes of health promotion, disease prevention and rehabilitation due to the inadequate allocation of resources and the absence of a sound health manpower development policy, and had contributed directly to severe mental and emotional stress in the Arab population. That point had been clearly illustrated in section 3.2.2 of the Special Committee's report, according to which there was no need to be a specialist to understand the implications of occupation and its repercussions on the mental health of the community.

On the subject of health manpower development, the Committee had observed in section 2.2 that there were two major constraints on the recruitment of medical staff, namely, budgetary inadequacy and low salaries offered to local personnel. The peoples of the occupied territories therefore had no say in the allocation of adequate resources for an important area in the health field and indeed played no part in the provision, management and decision-making process relating to their health system.

It was clearly impossible for any meaningful improvement to take place in the health conditions of the people under existing circumstances. The health and independence of peoples were closely related. If the Arab population in the occupied territories was to be happy and healthy, its independence must be restored. He wished therefore to reiterate the position of the Indian delegation that Israel's refusal to withdraw from the occupied territories constituted a grave threat to the health and well-being of the peoples of those territories and that conditions must be created to enable them to return to their homelands. In the meantime, WHO must continue to provide all possible assistance to meet the health needs of the Arab population. His delegation was confident that the draft resolution which it had co-sponsored would receive majority support.

Mrs WOLF (German Democratic Republic) welcomed the continuing WHO activities to improve the health conditions of the Arab population in the occupied Arab territories, including Palestine. The Organization, pursuant to the relevant United Nations resolutions and the mandate entrusted to it by Member States, had thus taken specific measures, tailored to the needs of the people living in the occupied territories.

Her delegation was however concerned at the absence of progress in removing the political causes of the existing situation. Dangerous tensions continued to prevail in the Middle East because of the aggressive policies pursued by Israel with the military and political support of imperialist circles. Through violence and terror, the Israeli authorities were stepping up the consolidation of their occupation regime in the West Bank, Gaza and the Golan Heights. In such circumstances, it was impossible to achieve basic improvements in the poor health conditions of the Arab inhabitants of those territories. She agreed fully with the Special Committee's conclusion that the problem of the Arab population's health in the sense of the WHO definition could be resolved only as a result of political action; there could be no health without peace, liberty and justice. What was required was a comprehensive, just and lasting settlement of the Middle East conflict, and that was one of the foremost tasks facing the international community. Her delegation attached great significance to the convening of the International Peace Conference on the Middle East with the participation of all States and the Palestine Liberation Organization; in that connection it fully supported the Soviet Union's Middle East initiative of July 1984 which, in its basic approach, was consistent with the decisions reached in 1982 at the Arab Summit Conference at Fez. The German Democratic Republic was firmly convinced that a peace settlement in the region could only be achieved on the basis of the complete withdrawal of Israeli troops from all occupied territories, the implementation of the legitimate national rights of the Palestinian people, including the right to establish its own independent State, and the guarantee of the security of all independent States in the region. She therefore supported the draft resolution before the Committee, and those countries that were in favour of maintaining the annual visits of the Special Committee of Experts.

Dr BAAS (Syrian Arab Republic) said that the item dealt with an issue which was of great concern to WHO, bearing in mind the goal of health for all by the year 2000. Over the years, the Special Committee of Experts had prepared seven reports which had demonstrated a continuing deterioration in the health conditions in the occupied Arab territories as a result of negligence and discrimination by the Israeli occupiers. Its latest report demonstrated that the solution of the health problems and related issues in the area was no longer incumbent on physicians alone, and that health, under the WHO definition, could not be provided without political action leading to the establishment of peace, liberty and
justice. Such action would be impossible until the occupation had ended and the Palestinian people were able to return to their homeland.

According to the report, local personnel had expressed doubts regarding the utility of the Special Committee's visits to the occupied territories. Such an attitude indicated a feeling of despair on the part of the citizens in the occupied territories at a time when the Israeli authorities were demonstrating arrogance in flouting resolutions of the World Health Assembly and other bodies.

At a moment when the international community was celebrating the fortieth anniversary of the fall of Nazism, it was unacceptable that Israel should be pursuing a policy of violence involving the invasion of Lebanon, massacres and the destruction of communities as well as the expropriation of land. Such inhuman practices could only be described as Nazism. In the view of his delegation, the draft resolution before the Committee represented the minimum condemnation which the international community could express regarding the inhuman Israeli practices and their consequences for the health of the populations in the occupied Arab territories. He hoped that the draft resolution would receive general support.

Mr KWEN Seung Yeun (Democratic People's Republic of Korea), speaking as a co-sponsor of the draft resolution before the meeting, emphasized that Israel was continuing its occupation of Arab territories, including Palestine, and was raising obstacles to the implementation of resolution WHA36.27, subparagraph 8(2), which requested the establishment of three health centres in those territories. People's health and lives were threatened in the occupied territories, where sanitary conditions were still in a backward state. WHO should take more positive measures to implement its resolutions concerning Israel; the latter should be required to dismantle its settlements and restore the legitimate rights of the Palestinian people. WHO should, moreover, give more practical help to improve health and sanitary conditions in the territories.

Mrs LUETTGEN DE LECRUGA (Cuba) recalled that her delegation had every year associated itself with the condemnation of Israel's violation of the rights of the Palestinian people. The Special Committee of Experts had stressed in its report that the occupation was a violation of human rights, and that health for all by the year 2000 could not be attained in the area if the occupation continued. Her delegation was convinced that unless a political and peaceful solution could be found to the Middle East conflict, and unless aggression and repression ceased, the health problems of the population of the occupied Arab territories would continue. She fully supported the measures to provide health assistance to the Arab population of those territories, including Palestine.

Dr AL-TAWEEL (Iraq) said that Committee B was discussing the situation of a people which had lost everything - its territory, its unity, its economy, its health, even its will. The condition of the population in the occupied Arab territories, including Palestine, was of special importance in that the acquisition of territory by force was outlawed by the United Nations Charter. It was therefore the duty of the United Nations and agencies including WHO to give the necessary importance and attention to the events which had occurred in those occupied territories over a number of years.

Israel had refused to cooperate with missions from international organizations conducting inquiries into the situation of the population in the occupied territories. For example, it had refused to cooperate with the International Committee of the Red Cross concerning the implementation of the Geneva Conventions. The Chairman of the Special Committee of Experts had referred to the difficulties it had encountered when attempting to obtain additional information. The Israeli authorities had closed a number of hospitals in the occupied territories, thereby compelling the population to use Israeli hospitals, which were very expensive; child care had deteriorated, and the infant mortality rate was very high. The report mentioned the establishment of Israeli settlements that had resulted in the water being cut off in a number of Arab villages, with a consequent deterioration of sanitary conditions.

His delegation, while expressing its gratitude to the Director-General for his efforts to implement resolution WHA36.27, subparagraph 8(2), hoped that he would continue to press for the complete implementation of that resolution.

Approval of the draft resolution now before the Committee would emphasize WHO's intention to carry out its task of improving the health situation of the Arab population in the occupied Arab territories, including Palestine.

Mr DOWEK (Israel) said that the wording and spirit of the draft resolution were totally and exclusively political in nature, both in its preamble and in its operative paragraphs. Its scope went well beyond the mandate of WHO as defined in Article 2 of the Constitution and
in various Health Assembly resolutions. In a less politicized body, and under any normal procedure, the draft resolution would have been not only rejected but declared irrecoverable for being in clear breach of the Constitution. Things being what they were, however, that would not happen. On the contrary, the draft resolution would be approved as in previous years by the same automatic majority. He knew for certain that his voice—although it was the voice of reason—was too weak to bring about a change in the course which the Health Assembly had taken under the influence of countries engaged in a diplomatic and propaganda attack on his country.

At the previous Health Assembly, the Israeli delegation had asked for the intervention of the Legal Counsel, but to no avail. The Assembly, yielding to the powerful forces behind the draft resolution, had decided that it was competent to deal with the topic. There was no point therefore in preaching to the deaf and repeating a futile exercise, but he felt compelled to stress that alleged competence and genuine constitutionality were two very different things. Indeed, in law-abiding societies, constitutions were adopted and constitutional courts created as safeguards against the abuse of power by those who controlled automatic majorities or who used force and political pressure in order to allocate competence and place themselves above the law. In that respect, there was no need to seek legal advice: only a few days ago the Director-General had reminded the Health Assembly that there were proper places in the United Nations system for the consideration of international political differences, namely the United Nations General Assembly and the Security Council; to deal with such differences by proxy in WHO was not only completely ineffective but could destroy the harmony of interest required for cooperation in promoting and protecting health. The President of the Health Assembly had made a similar plea that morning in the plenary meeting. The message was clear: if political issues were not kept out of WHO, their intrusion would jeopardize the very raison d'être of the Organization.

He was aware that certain delegations would contest the existence of an automatic majority, claiming that there was no more than a majority voting for or against a particular issue. But every member present knew that an automatic majority did exist, and that it did not vote on the merits of the case before it but rather in function of a predetermined political stand, group solidarity, or other extraneous considerations. It was a majority that voted automatically against another country whatever it did, good or bad. One example from the draft resolution would suffice to illustrate what was meant by an automatic majority: operative paragraph 4 called for the condemnation of Israel for "continuously raising obstacles to the implementation of resolution WHA36.27, subparagraph 8(2), which requests the establishment of three health centres". A similarly worded condemnation had been adopted in 1984, and it would certainly be adopted again by the current Health Assembly despite the fact that the Director-General had in both years expressed his entire satisfaction with the cooperation and effectiveness of the Government of Israel in the establishment of those health centres.

The reports of the Special Committee of Experts and of UNWRA were completely ignored by the sponsors of the draft resolution. The Special Committee's findings—mostly positive—had been discarded because they did not contain what those delegations would have like to hear. The Special Committee had reported only what its members saw with their own eyes during their extensive visit to the region, namely the satisfactory health situation of the Arab population in almost every field. The draft resolution had accordingly been formulated without regard to the facts and in order to serve political ends which had nothing to do with the health situation of the Palestinian Arabs. In fact, for the sponsors of the resolution and for the automatic majority which felt compelled to support them, the health conditions of the Palestinian Arabs were not relevant—indeed the Palestinian Arabs themselves were not relevant. The only relevant factor was the hatred of Israel and the maintenance of tension and strife in the Middle East, closing 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.

He suspected that even the sponsors of the draft resolution knew, as did everyone else present, that the health situation of all the inhabitants under Israeli administration, including the Palestinian Arabs, was far better than that of many countries in the world; that it was constantly improving; and that in many fields it had almost reached the standard of the most developed countries. Yet, Israel was the only country singled out every year for scrutiny and subsequent abuse in the Health Assembly. Citing at random some of the States sponsoring the draft resolution, he asked whether the delegates of those countries could solemnly assert that the health situation in their own countries was comparable with the very high standards prevailing among the Palestinian Arabs. WHO statistics were eloquent in that respect. It was more than amazing to see the Syrian Arab Republic among the sponsors of the draft resolution as a champion of the Palestinian cause, when Syria was in fact in armed conflict and bitter political confrontation with the Palestinians. Israel itself could not...
afford such a cynical approach. It was at the present time the only State engaged directly and actively in promoting the well-being, the safety, and the socioeconomic development of the Palestinian Arabs in Judea, Samaria and the Gaza district. In less than 19 years of Israeli administration, the Palestinians had made spectacular progress in every field, including health.

In the ritual debate and the subsequent resolutions each year, consistent and relentless efforts had been made to present Israel as systematically opposed to the extension of international aid and assistance to the Palestinian Arabs. On the contrary, Israel not only welcomed any assistance extended to the Palestinian Arabs for constructive purposes through the proper and legitimate channels, but cooperated in that field with UNDP, WHO and other agencies. The only positive element his delegation could find in the draft resolution was subparagraph 7(2), which called for increased assistance to the Palestinians. Israel totally rejected and vehemently opposed the slanderous propaganda attack against it made under the patently false pretence of assessing the health conditions of the Palestinian Arabs and allegedly granting them protection and assistance. It was clear from the wording of agenda item 32 that the object of the exercise was political and not humanitarian. The issues at stake were not whether the health conditions of the Palestinians should be assessed or whether they should be given assistance; all were aware that the issues were wider, deeper and more complex. Behind the careful diplomatic wording, the world community was being called upon to condone blind terrorism and relentless warfare; to block the way to peace and stability; and to give active help and support to those whose objective was the destruction of two Member States of both the United Nations and WHO, namely the Kingdom of Jordan and the State of Israel.

At the present crucial stage the peoples of the Middle East, including the Palestinian Arabs, were in no need of resolutions and debates aimed at fanning hatred and tension and hampering genuine efforts to promote a just and lasting peace. All those peoples had to live together and had no alternative but to find, by frontal negotiations, pragmatic and feasible solutions to all the outstanding issues. They had sooner or later to reach an acceptable compromise based on good faith and mutual respect. The Palestinian Arabs were bound to realize at long last where their real interests lay and take positive steps towards peace, cooperation and mutual understanding. They would find an immediate and earnest response from Israel, whose Government and people would go more than halfway to meet them.

The meeting rose at 17h40.
FIFTH MEETING
Tuesday, 14 May 1985, at 9h00
Chairman: Mr R. ROCHON (Canada)

1. SECOND REPORT OF COMMITTEE B (Document A38/32)

Dr JAKAB (Hungary), Rapporteur, read out the draft second report of the Committee.

The report was adopted (see document WHA38/1985/REC/2).

2. HEALTH CONDITIONS OF THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE: Item 32 of the Agenda (Resolution WHA37.26; Documents A38/10, and A38/INF.DOC./6, 8, 9 and 9 Corr.1) (continued)

Mr SOKOLOV (Union of Soviet Socialist Republics) said that the question of the health conditions of the Arab population in the occupied Arab territories had been before the Health Assembly since 1968, and numerous resolutions had been adopted calling for WHO administration of medical care to that population. The item had again been raised and had provoked a heated discussion. Previous Health Assemblies had called for the end of Israeli occupation and aggression. The Special Committee of Experts, in its report (document A38/10), had noted a deterioration in living conditions and had concluded that the health of the Arab population could only be maintained if political measures were taken to ensure peace, freedom and justice. The solution would thus only be found in a comprehensive settlement of the Middle East conflict.

In July 1984 the Union of Soviet Socialist Republics had put forward a constructive and realistic proposal for such a settlement, in accordance with the Charter of the United Nations on the question and its decisions, as well as with the 1983 Geneva Declaration and the conclusions of the Arab summit conference.

He expressed solidarity with those condemning the policies and actions taken by the occupying forces in the Arab territories. He voiced his concern regarding the living conditions of the Arab population in those territories. The transfer of Israel from the Eastern Mediterranean Region to the European Region had not solved the problems caused by its policy of aggression. The health and medical problems would persist until a political solution was found.

In view of the conditions obtaining in the region, he supported WHO action in providing health and medical assistance to the Arab population in the occupied Arab territories, including Palestine. He stated that he would vote in favour of the draft resolution on the health conditions of the Arab population in the occupied Arab territories, including Palestine. He thanked the Director-General of WHO and the Special Committee of Experts for their efforts in providing information on the situation of the Arab population in the occupied Arab territories. He requested that the Special Committee of Experts be asked to pursue its work on a yearly basis.

Mrs HU Sixian (China) expressed her concern for the health of the Arab population in the occupied Arab territories and her sympathy for the people. The total and unconditional withdrawal of Israeli troops from the occupied territories was the only way in which the Palestinian people would recover their national rights and lost territories, and improve their health status. She approved the efforts made by WHO to improve that status, and supported the draft resolution.

Mr BOYER (United States of America) said that it was clear there were strong emotional feelings and serious differences of opinion on the matter under discussion. He had hoped
that the Committee would heed the pleas of the Director-General, the President of the Health Assembly and the Chairman of the Committee regarding the pursuit of irrelevant political issues.

He considered the draft resolution to be harshly divisive and noted that much of the rhetoric in the debate had been in the same vein. WHO, as a technical health agency, should not be involved in such discussions. The bulk of the substance of the draft resolution was more appropriate to the work of the Security Council, the General Assembly and other bodies of the United Nations. It was not relevant to WHO. WHO could do nothing about the essentially political problems described. Further discussion of those issues was a waste of time; the health aspects, however, were a legitimate area for WHO concern.

He supported the option, mentioned by the Special Committee of Experts, of studying the health conditions of the Arab population in the occupied Arab territories every second year. He urged delegates to vote against the draft resolution and thus protect the reputation of WHO as a serious, technical, health organization.

Dr EL-SHERIF (Libyan Arab Jamahiriya) said that, although the delegate of one of the co-sponsors of the draft resolution, he was well aware that resolutions alone were insufficient to solve such a problem. He considered, however, that the draft resolution reflected the views of those who felt solidarity with the population of the occupied Arab territories. In the past, similar resolutions had been supported by a majority of delegates. This was not an unthinking, automatic majority, but one which consciously rejected the occupation. He hoped that the health conditions of the Arab population in the occupied Arab territories, including Palestine, would be improved. The issue was not political, in spite of the preposterous attempt by the delegate of Israel to portray occupation as a short-cut to improved health conditions. He called on delegates to support the draft resolution, as they had done in the past.

Mr ABBASSI TEHRANI (Islamic Republic of Iran) said that obstacles created by the zionist regime with regard to independent health and social services in the occupied Arab territories, including Palestine, were a direct result of zionist policies to perpetuate and expand its inhuman occupation. As the delegate of a co-sponsor of the draft resolution he strongly condemned the zionist occupation of Arab territories including Palestine, and believed that the violations of the basic rights of the moslem and Arab population in the occupied territories would continue and worsen unless their main cause was removed. In other words, the moslem and Arab population of the region would only be able to enjoy their basic rights when the occupied territories were totally liberated.

Dr Oweis (Jordan) thanked the Special Committee of Experts for its report and noted that it depicted the worsening health situation of the Arab population in the occupied Arab territories. He requested that reports be prepared annually. He called for support for the draft resolution, to be given in full consciousness of the suffering caused by occupation, colonialism or persecution. It was natural to vote automatically in favour of liberty, justice and basic rights, in support of people who were not enjoying adequate primary health care as a means of achieving health for all by the year 2000.

Mr HOSSAIN (Bangladesh) requested that Bangladesh be added to the list of co-sponsors of the draft resolution.

Mr AL-FARAGI (Egypt) expressed his concern at the alarming situation in the occupied Arab territories and said that it was linked to deteriorating health conditions. The dire situation of the Arab population was related to Israeli practices and policies carried out in violation of fundamental rights and despite condemnatory resolutions adopted in many international forums. He thanked the Special Committee of Experts for its report. The WHO definition of health as "a state of complete physical, mental and social well-being" should be borne in mind in considering the health conditions of the Arab population in the occupied Arab territories. It implied more than the mere absence of disease; it was a global objective and provided a means for man fully to exercise his rights.

He stressed the deterioration in a mental and social well-being of the Arab population in the occupied territories, as noted in the report of the Special Committee of Experts (A38/10, section 3.2.2), and pointed out that it was exacerbated by the Israeli military presence, the inhuman treatment of prisoners, the confiscation of goods and property, and deportation. The situation would have serious consequences for future generations, not to mention its effects on the present generation. It would be difficult to cure such suffering. Nor had there been an improvement in physical well-being; the report of the Special Committee of Experts had stated that an increase or decrease in the number of
hospital beds would have no significant influence on either the situation or the dynamics of development. The report also noted problems with drinking-water and waste disposal, obstacles to the participation of the Arab population in health care delivery systems, higher hospital costs, etc. The only way to remedy the situation and improve the physical, mental and social well-being of the Arab population was to end Israeli occupation and to restore to the Palestinian people their inalienable social, economic and political rights, including the right to self-determination.

Dr TAPA (Tonga) said the item now under discussion had been on the agenda of Health Assemblies for as long as he could remember, at least since 1976. His delegation had always regarded it as one of great importance because of its potentially divisive and disunifying effects on the work of WHO. Although the health conditions of the Arab population in the occupied Arab territories including Palestine was a proper subject for the Assembly to consider, he believed that the political issues which attached to it could more appropriately be discussed in other international forums, leaving the Health Assembly to devote itself to the task laid on it by the Constitution, relating to the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social condition.

Great hopes had been aroused by the adoption by the Health Assembly in 1977 of the goal of health for all by the year 2000. 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 was another principle enumerated in the Preamble to the WHO Constitution. Unfortunately, however, the item under discussion had not inspired a spirit of cooperation, but had rather led to divisions between WHO Member States. Only a year ago the Health Assembly had adopted resolution WHA37.13 concerning the spiritual dimension of the Global Strategy for Health for All, and he urged Member States to show genuine awareness of that spiritual dimension, and not merely to pay lip-service to it, before it was too late. The goal of health for all would never be achieved by the year 2000 if the matter currently under debate was approached year after year in the same spirit. He appealed to delegates to begin by showing a spirit of reconciliation, in accordance with resolution WHA37.13, which would make it possible to work together for acceptable solutions to the health problems raised by the item.

He respected the views of the co-sponsors of the draft resolution, but found it difficult to give it his support. In order to avoid any possible feelings of ill-will towards those who, like himself, could not vote in favour of the resolution, he proposed that, in accordance with Rule 78 of the Rules of Procedure of the Health Assembly, a vote be taken by secret ballot.

Mr ISMAIL (Sudan) expressed his appreciation of the Director-General's efforts to improve the health of the Arab population in the occupied Arab territories, including Palestine, and thanked the Special Committee of Experts for its report (document A38/10). The report made it clear that health conditions in the territories occupied by Israel had deteriorated, and in particular that there was a lack of manpower and of proper infrastructure, as well as restrictions at the managerial level. Further, the Israeli authorities were refusing to allow health personnel to enter the territory, and were creating obstacles to their training. The report confirmed yet again that Israel was carrying out a policy of discrimination against the Arab population, with the aim of forcing them to leave their country so that it could annex the territories.

His delegation would like the Special Committee of Experts to continue its work, and to submit regular reports to the Health Assembly.

He fully endorsed the draft resolution under discussion, and wished to be included among its sponsors.

Dr MIRANDA (Nicaragua), speaking as the delegate of a co-sponsor of the resolution, said he wished to take up the challenge made to him by the Israeli delegation on the subject of health indicators. Some three years earlier WHO's Director-General had visited the recently inaugurated Children's Hospital of Nicaragua (of which he himself was Director) and had been greatly impressed to see how only three years after the revolution, and after a war which had left more than 50 000 dead in a country of less than three million people, it had been possible for such a hospital to be placed free of charge at the service of the people. Indeed, the Hospital was provided with an infrastructure and with scientific and technical facilities that were the equal of any leading hospital in a developed country. On that occasion he had told Dr Mahler that peoples who had achieved true revolution succeeded in attaining in years what they had hitherto been unable to achieve in centuries. Since that time seven more hospitals of the same high quality had been made available to the people, and
there was no doubt that in the medium term Nicaragua would achieve higher health indicators than Israel, as many other revolutionary countries in Latin America had already done.

Both he himself and the leader of his delegation still bore the scars of the war in which bomb attacks had been made by aircraft donated by Israel to Somoza, enabling him to massacre women and children by destroying the hospitals in which they had taken refuge. In fact, three hospitals had been reduced to ashes, and thousands of children now lay in common graves. Israel had provided sophisticated weaponry to the shock troops of Somoza, and was continuing to arm and train mercenaries who were still bringing bloodshed and destruction to Nicaragua. He felt no obligation to congratulate the delegate of Israel for coming to the Health Assembly to defend the indefensible, nor would he shake him by the hand, because as delegate of Nicaragua he spoke on behalf of a heroic people who seven years earlier had risen as one man to rid the world of Somoza.

He confirmed strongly that Nicaragua fully supported the heroic struggle of its Palestinian brothers.

Mr TAMFIQ (Kuwait) said that his delegation was opposed to the holding of a secret ballot. He requested a roll-call vote in accordance with Rule 74 of the Rules of Procedure.

The CHAIRMAN invited the Committee to vote on the request for a secret ballot.

The request was rejected by 61 votes to 26, with 15 abstentions.

The CHAIRMAN invited the Committee to proceed with a roll-call vote, as requested by Kuwait.

A vote was taken by roll-call, the names of the Member States being called in the English alphabetical order, starting with Kenya, the letter K having been determined by lot.

The result of the vote was as follows:

In favour: Algeria, Angola, Bahrain, Bangladesh, Benin, Botswana, Bulgaria, Burkina Faso, Burundi, Cape Verde, Central African Republic, China, Comoros, Cuba, Cyprus, Czechoslovakia, Democratic People's Republic of Korea, Democratic Yemen, Djibouti, Ecuador, Egypt, Ethiopia, German Democratic Republic, Greece, Guinea-Bissau, Hungary, India, Indonesia, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Madagascar, Malaysia, Maldives, Mali, Malta, Mauritania, Mongolia, Morocco, Mozambique, Nicaragua, Nigeria, Oman, Pakistan, Philippines, Poland, Qatar, Saudi Arabia, Senegal, Somalia, Spain, Sri Lanka, Sudan, Suriname, Syrian Arab Republic, Thailand, Togo, Tunisia, Turkey, Union of Soviet Socialist Republics, United Arab Emirates, Vanuatu, Viet Nam, Yemen, Yugoslavia, Zambia.

Against: Australia, Belgium, Canada, Denmark, France, Gabon, Federal Republic of Germany, Iceland, Ireland, Israel, Italy, Liberia, Luxembourg, Monaco, Netherlands, New Zealand, Norway, Papua New Guinea, Paraguay, Switzerland, Tonga, Trinidad and Tobago, United Kingdom of Great Britain and Northern Ireland, United States of America.

Abstaining: Argentina, Austria, Bolivia, Brazil, Chile, Democratic Kampuchea, El Salvador, Finland, Jamaica, Japan, Lesotho, Mexico, Peru, Portugal, Samoa, Sweden, Venezuela.

Absent: Afghanistan, Albania, Antigua and Barbuda, Bahamas, Barbados, Bhutan, Brunei Darussalam, Burma, Cameroon, Chad, Colombia, Congo, Cook Islands, Costa Rica, Dominican Republic, Equatorial Guinea, Fiji, Gambia, Ghana, Granada, Guatemala, Guinea, Guyana, Haiti, Honduras, Ivory Coast, Kenya, Kiribati, Lao People's Democratic Republic, Malawi, Mauritius, Nepal, Niger, Panama, Republic of Korea, Romania, Rwanda, San Marino, Sao Tome and Principe, Seychelles, Sierra Leone, Singapore, Solomon Islands, Swaziland, Uganda, United Republic of Tanzania, Uruguay, Zaire, Zimbabwe.

The draft resolution was therefore approved by 69 votes to 24, with 17 abstentions.¹

The CHAIRMAN announced that pursuant to Rule 77 of the Rules of Procedure delegates might make brief statements consisting solely of an explanation of vote; however, no such explanations could be given by sponsors of the resolution.

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA38.15.
Mr DOWEK (Israel) said that his delegation had voted against the draft resolution. It did not understand why its sponsors had been afraid of and so categorically opposed to a secret ballot.

There was no point in reiterating the arguments his delegation had put forward in the past, but it did appear necessary to reiterate, forcefully and fully, that Israel considered the resolution to be purely political and totally unfounded and therefore illegal, unconstitutional, null and void. Every paragraph of the resolution was highly questionable, and the real intent of the sponsors had been cloaked in distorted and illogical arguments and the negation of obvious facts. The sponsors had apparently believed that the extensive reference to previous illegal resolutions would make yet another illegal resolution more legal, but they would not thereby achieve their aim.

For reasons of principle, moral decency and respect for the real goals of WHO and of international cooperation, Israel had voted against the draft resolution as yet another political exercise in disregard of the facts, justice and common sense. The sacred duty and objective of the Government of Israel was to protect the vital interests of all sectors of the population under its administration, both Arab and Jewish. It was doing that, and would not be deterred by the political considerations forced upon the world community by those who endeavoured to discredit Israel, weaken its political situation and foster their own narrow political interests. The anti-Israel ritual had been carried out to its logical conclusion.

The CHAIRMAN, requesting the delegate of Israel to be brief, said that a three-minute explanation of vote would be appropriate.

Mr DOWEK (Israel) replied that his delegation was not in a position, having been condemned, to explain its vote in two minutes, and requested that he be accorded the right to finish his statement as he felt necessary. It was his Government's wish to deliver a statement and there was a question of fairness and justice involved. Its statement would not be long, but would go beyond the three minutes allocated.

The CHAIRMAN granted the Israeli delegate's request, while at the same time urging brevity.

Mr DOWEK (Israel), continuing his statement, said that Israel was a small and peace-loving country, but was depicted as the arch-Satan and as the very personification of evil. The list of crimes imputed to it by the phantasmagoric and nightmarish imagination of the sponsors of the resolution was exhaustive in its absurdity. It was more significant that the real authors had seen it fit, one day before the opening of the current debate, to carry out four criminal and cowardly bomb attacks against the population of Jerusalem. Even more significant was that one of those attacks had been directed at one of the major hospitals, but fortunately nobody had been hurt.

Israel not only rejected the spirit and letter of the draft resolution, it also strongly protested against the deliberate politicization of health issues, and the dubious standards imposed on the Health Assembly by a few delegations which did not hesitate to ride roughshod over constitutions, legality and fairness. The previous year, after resolution WHA37.26 had been passed, he had addressed a letter to the Director-General on the instructions of his Government.

Dr HACEN (Mauritania), speaking on a point of order, expressed the wish that the Rules of Procedure of the World Health Assembly be applied justly, and to all delegations.

Dr EL-SHERIF (Libyan Arab Jamahiriya) supported that point of order. While not wishing to interfere with the rights of the Israeli delegation, he felt it was undesirable that the meeting be turned into a propaganda forum.

Mr TALEB (Djibouti), speaking on a point of order, said that the Mauritanian delegation had stressed the procedural position that should be applied in the Organization. The previous evening and again at the current meeting, the Israeli delegation had made remarks about the countries of various delegations present. Due respect should be ensured.

The CHAIRMAN said that in the light of those appeals he would allow the delegate of Israel one more minute to complete his statement.

Mr DOWEK (Israel) said that the content of and positions expressed in his letter to the Director-General applied equally to the resolution that had just been passed. Israel rejected the resolution as a whole, and every provision individually, whether in the preamble or in the operative paragraphs, with the exclusion of subparagraph 7(2). Since national
suicide was not yet an international obligation, Israel could not and would not receive any committee seeking its mandate in an illegal resolution whose implementation meant nothing but the elimination of the State of Israel. The right to life was the first and most fundamental human right and applied not only to individuals but to States.

Israel would reject time and again resolutions aimed at bringing about its destruction, but it would unwaveringly continue to extend its hand in peace to any country or people, and especially to the Palestinian Arabs, ready to take that hand in good faith and march with it towards understanding, cooperation and peace. Israel would continue to cooperate with WHO with frankness, openness and dedication, as it had always done, regardless of any political considerations or after-thoughts. The Government of Israel would continue to fulfil its duty towards all sectors of the population, Arabs and Jews alike, and would continue to provide in the most effective way for the health needs of the Arab populations.

Mrs VAISTO-MELLERI (Finland) said that the position of the Finnish Government on the Middle East question was well known: a comprehensive, just and lasting settlement in the Middle East had to be based on the principles of United Nations Security Council resolutions 242 and 338. In the peace-seeking process, the security of all States as well as the rights of all peoples in the Middle East had to be respected, including the right of the Palestinians to self-determination. Finland had made its position clear on Israel's settlement policies, which continued to breed frustration, violence and problems in various sectors, including the health sector. It supported additional health and medical assistance through WHO and UNRWA in order to improve the difficult living conditions of the population of the occupied Arab territories. The resolution just passed contained some elements and formulations which went beyond the competence of WHO and were too far-reaching, and the Finnish delegation had therefore abstained from voting.

Mrs NASCIMBENE DE DUMONT (Argentina) said that Argentina's position on the political problems of the Middle East had been repeatedly expressed in the relevant international forums. The Argentinian delegation fully supported the efforts of WHO to improve the health situation of the Arab population in the Arab territories occupied by Israel since 1967. However, Argentina had always considered that expressions of condemnation with regard to any given country were inappropriate in resolutions adopted by a technical body like the World Health Assembly, whose task was essentially humanitarian, and her delegation had therefore been compelled to abstain from voting on the draft resolution.

Mr DE CARVALHO-LOPES (Brazil) said that Brazil had traditionally supported all resolutions in various United Nations forums concerning the rights of the Palestinian people to self-determination, and in WHO in particular had voted in favour of resolutions on health conditions in the occupied Arab territories. While it had always supported and would always support the same principles, the Brazilian delegation had abstained from voting on the draft resolution because it would have preferred the text to have been more moderately worded and clearly to have reflected the mandate of the Organization on health matters.

Mr PINTO DE LEMOS (Portugal) said that his delegation shared the concerns expressed about the health conditions of the Arab population in the occupied Arab territories. Portugal had taken measures to reinforce WHO's action to improve the health of the Arab population in those territories. However, the Portuguese delegation had abstained from voting because it could not subscribe to some of the provisions contained in the draft resolution, which exceeded WHO's mandate. Portugal's position on the Middle East was well known and had been expressed on a number of occasions in the appropriate United Nations forums.

Miss RIDDELL (New Zealand) said that her delegation had voted against the draft resolution. The position of her Government on the Middle East situation was well known and needed no elaboration. New Zealand continued to support Security Council resolution 242 as the basis for a comprehensive peace settlement in the region and the right of the Palestinians to self-determination. Its vote should not be interpreted as indicating a lack of concern at the situation in the occupied territories, or for the health and welfare of the Palestinians, neither should it be seen as opposing the work of the Special Committee of Experts. On the contrary, New Zealand considered it entirely appropriate that WHO should contribute in any way possible to the further development of health systems in the occupied territories, and to the improvement of their people's health. Her delegation was concerned about the continued intrusion into the resolution of political elements which were outside the competence of WHO, and in particular about the inclusion of language inconsistent with the provisions of Security Council resolution 242. For such reasons, which were unrelated to what should have been the central purpose of the resolution, it had regretfully been obliged to vote against it.
Mr GROTH (Sweden) said that his delegation recognized that the occupation of Arab territories and the Israeli settlement policy had created a number of problems in various sectors. The Swedish Government had repeatedly and strongly criticized Israeli policy with regard to the occupied territories and had clearly expressed its views many times in the United Nations General Assembly and other competent forums. WHO should do everything possible in the health sector in favour of the population affected. However, the Swedish delegation had abstained from voting because the draft resolution contained formulations that were too far-reaching and did not fall within the competence of the Organization.

Mr CAMPBELL (Australia) said that his delegation shared the concerns of other delegations about health conditions in the occupied territories. The Australian Government had consistently urged all parties concerned to respect their international obligations pursuant both to the Constitution of WHO and to the relevant Geneva conventions. However, his delegation had been unable to support the draft resolution because it considered that it was unbalanced and because it regretted the introduction of extraneous political issues which went beyond the competence of the Health Assembly and its debate.

The meeting rose at 10h45.
SIXTH MEETING
Tuesday, 14 May 1985, at 14h30

Chairman: Mr R. ROCHON (Canada)

COLLABORATION WITHIN THE UNITED NATIONS SYSTEM: Item 33 of the Agenda

General matters: Item 33.1 of the Agenda (Documents A38/11 and A38/INF.DOC./5)

Mrs BRÜGGEMANN (Director, Programme for External Coordination) said that, since the last Health Assembly, the Organization had continued to concentrate its cooperation within the United Nations system on activities with actual or potential implications for health development, as prescribed by the Global Strategy for Health for All. Document A38/11 briefly summarized some of the main issues considered by the United Nations Economic and Social Council at its 1984 sessions and by the United Nations General Assembly at its thirty-ninth regular session. The document highlighted issues of particular concern to the work of WHO and provided information on activities that had taken place in collaboration with other bodies of the United Nations system, including UNICEF, UNDP, UNFPA and many others.

International conferences, international years and United Nations decades for special subjects of concern to WHO had included the International Conference on Population held in Mexico City in 1984 and the Second International Conference on Assistance to Refugees in Africa held in Geneva, also in 1984. The World Population Plan of Action, which had been adopted in Mexico and which had affirmed that population goals and policies were an integral part of social, economic and human development, was much in line with the Alma-Ata Declaration on Primary Health Care.

The Programme of Action adopted by the Second International Conference on Assistance to Refugees in Africa was highly relevant to WHO's involvement in emergency relief activities in Africa, including relief to refugees.

The United Nations Economic and Social Council and General Assembly had adopted a number of resolutions concerning women. WHO would be taking an active part in the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women, due to be held in Nairobi in July 1985, and the Director-General was to address that Conference.

The year 1985 had been declared International Youth Year: Participation, Development, Peace. The Economic and Social Council and the General Assembly had adopted a number of resolutions designed to promote activities in support of youth. She drew attention to the exhibition on youth in the main hall of the Palais des Nations. WHO has chosen the subject "Healthy youth - our best resource", as the subject of World Health Day 1985. The Director-General's conference on World Health Day had been devoted to a lively discussion on the meaning of health with various groups of young people from Geneva.

A further major international event, to which the President of the Health Assembly and the Director-General had already referred, was the fortieth anniversary of the United Nations in 1985, which WHO planned to commemorate with a number of activities.

In the spirit of WHO's strong belief in development, the Organization had been actively involved in the first global review and appraisal of the implementation of the International Development Strategy for the Third United Nations Development Decade. In addressing the second regular session of the Economic and Social Council in July 1984, the Director-General had recalled that the Global Strategy for Health for All constituted WHO's contribution to the implementation of the Development Strategy.

During the past year, the General Assembly had adopted a number of resolutions related to the use of drugs, including one concerning protection against products harmful to health and the environment, which was a topic of great concern to WHO. A copy of that resolution was annexed to document A38/11. Since that document had been finalized, the Secretary-General of the United Nations and the Director-General of WHO had signed a Memorandum of Understanding, which provided for specific collaborative measures to inform the public on products harmful to health and the environment. The Executive Director of the
United Nations Environment Programme was also party to the understanding to ensure coordinated joint action. The intensive preparations for the Memorandum of Understanding had proved a most satisfactory experience in joint action by the group of high officials of the three organizations.

Turning to WHO's continued and intensified collaboration with UNICEF, UNDP, the World Bank, UNFPA and many others, she said that the joint efforts had shown a steadily progressive trend that could be seen, for example, in WHO's activities with UNICEF in the areas of primary health care and child survival, with UNDP and the World Bank in development activities, and particularly in enhancing the international flow of resources for health, and with UNFPA in the field of maternal and child health, including family planning.

Referring to WHO's contribution to peace and disarmament, she drew attention to the progress report by the WHO Management Group on the follow-up on the Study of the Effects on Nuclear War on Health and Health Services (document A38/INF.DOC./5), which provided information on the Group's study of the climatic, radiation, and long-term effects of nuclear explosions. The Director-General's report (document A38/11) in which that information was summarized also referred to many other important issues, including the resolutions of the General Assembly and the Economic and Social Council relating to decolonization and apartheid, which were relevant to the Committee's review of WHO programme activities in that field under agenda item 33.5. In highlighting some of the issues in the report most relevant to WHO's activities she was in no way diminishing the importance of other issues.

Dr PASTORE (International Physicians for the Prevention of Nuclear War), speaking at the invitation of the CHAIRMAN, welcomed his nongovernmental organization's admission to official relations with WHO and pledged its support for the cooperation of the Organization and the United Nations system as a whole in the cause of peace and disarmament. Resolution WHA36.28, which identified 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, endorsed the conclusion that it was impossible to prepare health services to deal in any systematic way with a catastrophe resulting from nuclear warfare, and that nuclear weapons constituted the greatest immediate threat to the health and welfare of mankind. That was the basic tenet of his organization.

At the time of that body's creation in Geneva in December 1980, three physicians from the United States of America and three from the Union of Soviet Socialist Republics had identified the prevention of nuclear war as their single most important concern, and had eschewed political issues and focused on the medical consequences of the nuclear arms race and nuclear war.

Since that time, the group had grown into a federation with 140 000 members in 34 eastern and western countries. Its attention was focused on educating physicians and patients about the short-term and long-term medical effects of nuclear war. Many of its members had been involved in medical research in Hiroshima and Nagasaki sponsored by the Radiation Effects Research Foundation, formerly known as the Atomic Bomb Casualty Commission. The widely disseminated WHO report on "Effects of nuclear war on health and health services", which was a thorough treatise on the devastating effects of nuclear weapons upon human beings, had drawn heavily on the medical experience of Hiroshima and Nagasaki. It contained one of the key messages of his organization, namely, that no health service in any area of the world could deal adequately with the hundreds of thousands of people who would be seriously injured by blast, heat or radiation from even a single one-megaton bomb, and that even the death and disability that could result from an accidental explosion of just one bomb from the enormous stockpiles of weapons could overwhelm national medical resources.

"International Physicians" had also taught physicians and the general public that the world's nuclear arsenals now had the firepower of one million Hiroshimas. Therefore, the medical catastrophe studied in Japan could only be seen as a warning. The holocaust of a nuclear war as it would now be fought overwhelmed the imagination even of those who had most actively studied the past medical effects.

The contribution of "International Physicians" to medical expertise at the Disarmament Conference in Leningrad in June 1984, sponsored by the United Nations, was but one among many examples of such cooperation. It was giving wide dissemination to the progress report of the WHO Management Group (document A38/INF.DOC./5), whose conclusions on the climatic effects (the "nuclear winter") and the psychosocial and mental health aspects of the nuclear war threat were particularly important.

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As a result of its educational efforts, "International Physicians" had been awarded the 1984 UNESCO Peace Education Prize. It worked on the basis of international cooperation rather than confrontation. Its Executive Committee comprised leading doctors from eastern and western bloc countries, and it functioned entirely as a nonpolitical organization, devoted only to the prevention of nuclear war through medical education. Three physicians from the United States and three from the Soviet Union who had appeared on Soviet television in 1982 had been able to demonstrate complete unanimity regarding the medical aspects of nuclear war and the nuclear arms race. The programme had been seen by a hundred million viewers in the Soviet Union and tens of millions in the West, and the United States press had commended its nonpolitical and non-confrontational approach. "International Physicians" had promoted international dialogue among physicians on the medical aspects of nuclear war in recent international regional seminars in South America and the South Pacific (New Zealand and Australia). Those activities were consistent with the recommendations in resolution WHA36.28.

The theme of cooperation rather than confrontation would be the main focus of the fifth World Congress, to be held in Budapest in June 1985. Major attention at the plenary session would be devoted to cooperative ventures among physicians from East and West. "International Physicians", which was in complete agreement with WHO's goal of health for all by the year 2000, welcomed the fact that the Director-General of WHO was to address its opening plenary meeting, which was also to be addressed by Willy Brandt and Bruno Kreisky. There was to be an important panel discussion based on the theme "Medicine today; costs of confrontation; proposals for cooperation". Speakers at the session were to include the Director of the United States Centers for Disease Control, the Director of the WHO Expanded Programme on Immunization, the Director-General of the Indian Council for Medical Research and the Director of the USSR Health Information Institute. He was confident that the discussion would help to make world physicians more aware of WHO's proposal for the inoculation of children throughout the world with a view to eliminating common and preventable childhood diseases.

WHO's successful efforts in eradicating smallpox in 1977, to which "International Physicians" had frequently drawn attention, had cost US$ 300 million, which was equivalent to the cost of five hours of the arms race. "International Physicians" hoped that the victory over smallpox would be typical of achievements to come if mankind would direct its resources away from destructive competition and towards health and human services.

Research sponsored by "International Physicians" in the Soviet Union, the United States of America and many European countries had demonstrated that the world's children shared common fears about the risk of nuclear war. The health of children throughout the world had fallen prey to the nuclear arms race and the tragic misallocation of the world's scarce resources.

The fortieth anniversary of Hiroshima and Nagasaki coincided with the fortieth anniversary of the United Nations. From the ashes of the past glowed the sparks of hope for the future.

"International Physicians" looked forward to long and productive cooperation with WHO so that mankind's potential for health could be realized. It endorsed and would promote resolutions of the United Nations and WHO on physicians and the nuclear arms race, and it strongly supported General Assembly resolution 39/53 calling for a comprehensive nuclear test ban treaty.

Mr CHAUHAN (India), expressing appreciation of the establishment of the Management Group to review information on the effects of nuclear war on health and health services, and welcoming the publication and dissemination of the 1984 report on the subject, observed that the interim report (document A38/INF.DOC./5) showed that the effects of nuclear war would be more serious than had been estimated earlier. As well as serious climatic effects, the radiation effects would produce more casualties than had been calculated previously. The long-term effects, transboundary effects and effects of attacks on nuclear power installations were also matters of serious concern.

The psychosocial and mental health effects of nuclear conflict or threat of such conflict were of particular interest, and he hoped that WHO would continue its work on that aspect.

Section 6 of the report highlighted the need for more education and greater awareness among physicians and health workers about the consequences of nuclear war.

The Indian delegation, which had been among the many delegations that had supported resolution WHA36.28, considered that WHO should continue its work to promote greater public awareness of the dangers of nuclear war, which would help to strengthen the efforts for nuclear disarmament and put an end to the spectre of nuclear war. His delegation therefore fully supported the work of the WHO Management Group and looked forward to receiving a more comprehensive report at the Thirty-ninth World Health Assembly.
Mrs WOLF (German Democratic Republic) said that the report of the Director-General gave a comprehensive survey of recent developments in health-related activities in the United Nations system: that information was extremely useful, since overall United Nations efficiency in addressing global problems depended on the responsible and coordinated action of each of its components. It was instructive to review WHO's activities in that light. In 1985, when the international community was celebrating the fortieth anniversary of the creation of the United Nations, WHO could hardly expect to promote international cooperation in health-related matters and disease control unless it also contributed actively to the cause of peace. Her delegation had noted with satisfaction that it was increasing its capacity to discharge that responsibility but felt that it must intensify its efforts to implement creatively the General Assembly and Economic and Social Council resolutions aimed at resolving fundamental contemporary political issues and at averting the threat of human self-destruction. Her delegation had noted with interest the information contained in A38/INF.DOC./5 regarding international publicity about the danger of nuclear war and welcomed the Director-General's undertaking to keep the Health Assembly informed about the activities of Member States in that field.

Mr SOKOLOV (Union of Soviet Socialist Republics) thanked the Director-General for his report (document A38/11), which contained useful information on decisions adopted by the organizations of the United Nations system: he referred in particular to paragraphs 2.18, 2.19 and 2.20, which described resolutions of the Economic and Social Council and the General Assembly on the fortieth anniversary of the foundation of the United Nations and the end of the Second World War. In that connection, it should be noted that the United Nations and its specialized agencies, including WHO, were making an important contribution to the maintenance of peace and the strengthening of international cooperation.

In compliance with the General Assembly's recommendations, the Soviet Union had established a commission to celebrate the fortieth anniversary and the International Year of Peace, and his delegation had noted with appreciation that WHO would also undertake a number of specific activities in connection with the Year.

Section 5 of the Director-General's report and A38/INF.DOC./5 contained useful information about WHO's efforts to implement resolution WHA36.28 on the role of physicians in the maintenance of peace: his delegation supported those efforts and looked forward to a detailed debate on a full report on the subject at the next Health Assembly.

Mr PAPULI (United Nations Industrial Development Organization) said that UNIDO was gratified that WHO's programme budget for 1986-1987 offered several opportunities for collaboration between the two organizations in such fields as environmental health, traditional medicine, essential drugs and vaccines. UNIDO's programme of work included a system of consultations designed to increase the share of developing countries in world industrial production and had been conceived not merely as a project-generating mechanism but as a unique means of fostering international industrial cooperation between developed and developing countries. UNIDO was currently carrying out the recommendations of the 1983 Budapest consultation, in which WHO had participated, relating to the pharmaceutical industry and covering contractual arrangements for the production of drugs; availability, pricing and transfer of technology for bulk drugs and their intermediates; the development of drugs based on medicinal plants; and the production of biologicals. Some of the recommendations required coordination with WHO and other United Nations organizations. The Directory of sources of supply of 26 essential bulk drugs, their chemical intermediates and some raw materials had been revised and updated; it would gradually be enlarged to cover the entire WHO list of essential drugs.

UNIDO was preparing guidelines for improving management skills for the procurement of chemicals, transferring expertise in the production of pharmaceutical chemicals and pharmaceutical formulations, surveying national industrial drug policies and establishing a process and research development centre, and work had begun on a directory of drugs based on medicinal plants.

UNIDO had continued to promote local production of pharmaceuticals in developing countries in line with WHO's specifications through the use of indigenous resources such as medicinal plants and petrochemical products, the adaptation of technology for local production of pharmaceutical chemicals, the enhancement of preventive measures by promoting production of biologicals and the strengthening of the capabilities of national institutions to sustain research and development efforts.

UNIDO had pursued projects for the industrial utilization of medicinal and aromatic plants in Afghanistan, Burkina Faso, Cameroon, Mali, Rwanda, Thailand, Turkey and the United Republic of Tanzania, and had started new projects in Burundi, Guatemala and Madagascar. A multipurpose plant for the bulk production of essential synthetic drugs had been inaugurated
in Cuba in March 1985, and similar projects were being implemented in Brazil and the Islamic Republic of Iran. A primary health care project implemented jointly by UNIDO and WHO was nearing completion in Nepal.

Both UNIDO and WHO had the basic goal of improving the quality of life for all. The high-level discussions on cooperation between WHO and UNIDO that had recently been held in Geneva had illustrated their desire to promote a greater level of collaboration and to enhance coordination in areas of complementary action. UNIDO would soon be converted into a specialized agency; it was to be hoped that that development would offer even greater opportunities for collaboration with WHO to benefit all the countries that the organizations both served.

Dr MORALES ARAUJO (Venezuela) said that his delegation was particularly interested in the international campaign against drug trafficking and would welcome additional information on collaboration between WHO and the United Nations Division of Narcotic Drugs.

Mrs CHEN Haihua (China) said that, having read the report of the Director-General, her delegation was convinced that WHO had collaborated fruitfully in its sphere of competence with other organizations of the United Nations system. Referring to paragraph 2.23, she said that the declaration of 1986 as the International Year of Peace was a historic event and, since her country was totally committed to peace, it welcomed the plans for the year which WHO had developed. WHO was clearly capable of making a unique contribution to the preservation of peace: that very goal was a fundamental tenet of Chinese foreign policy and was, moreover, an essential prerequisite for ensuring the health of the world's population.

Drug abuse was a scourge which jeopardized the health of many young people throughout the world, and her delegation accordingly welcomed WHO's efforts to strengthen drug abuse control measures. Since 1949, many steps had been taken in her country to achieve the eradication of opium abuse. The sale of drugs was strictly regulated in China. Her country was willing to cooperate with others in efforts to control the plague of drug abuse.

Dr KLIVAROVA (Czechoslovakia) said that her delegation valued highly WHO's efforts in pursuance of United Nations resolutions on peace and disarmament. She particularly welcomed the work of the WHO Management Group aimed at supplementing and updating the WHO report on "Effects of nuclear war on health and health services", a report which had been widely consulted in her country, especially by the Czechoslovak branch of International Physicians for the Prevention of Nuclear War. She hoped that the final report would be available for the next Health Assembly.

In 1985 the United Nations was celebrating its fortieth anniversary: its birth had been linked to the victory of peace-loving peoples over Hitler's fascism and Japanese militarism, and the cost of that victory in human suffering and sacrifice must never be forgotten. The fact that the nations of Europe had been able to coexist creatively for the past 40 years was also a victory for peace-loving forces.

The DIRECTOR-GENERAL, referring to the question raised by the delegate of Venezuela, said that cooperation between WHO and the United Nations Division of Narcotic Drugs had been greatly improved in recent years. He recalled that the Executive Board had had before it a report prepared by the Secretariat on the subject (document EB75/14) and said that a copy would be made available to the delegate of Venezuela.

Dr HAPSA (representative of the Executive Board) introduced the draft resolution on additional support to national strategies for health for all in the least developed among developing countries, recommended by the Executive Board in resolution EB75.R14. Its genesis lay in the Executive Board's discussion of the deteriorating health situation in many drought- and famine-stricken African countries and the needs of the least developed countries which had been most severely affected by the global economic crisis. Their highly restricted resource base, complicated by weak health infrastructures and insufficient qualified health personnel, had made it extremely difficult for those countries to take any steps to implement their national health strategies. Special efforts to support health development in the least developed countries were very much in line with the Substantial New Programme of Action for the 1980s for the Least Developed Countries; under that initiative, WHO had collaborated with UNDP, the World Bank and other agencies of the United Nations system in mobilizing support for those countries.

Nineteen eighty-five would be marked by a mid-decade review of progress in implementing the Programme of Action, but it was clear that greater efforts would be required if the Programme's goals were to be reached, and the time was therefore ripe for the Member States of WHO to demonstrate their combined resolve to support health development in those countries.
In addition to the technical support provided to all developing countries, concrete WHO action in favour of the least developed countries had taken two forms. First, the Special Account for Assistance to the Least Developed among Developing Countries in the Voluntary Fund for Health Promotion had provided a special avenue for extrabudgetary support, permitting some US$ 11.3 million to be channelled to those countries. The support provided to those countries from the regular budget and extrabudgetary resources during the biennia 1982-1983 and 1984-1985 was currently estimated at some US$ 180 million. Second, WHO had been assisting least developed countries in the conduct of country resource utilization reviews, involving in many instances not only the health sector, but also other social and economic sectors as well as bilateral and multilateral development agencies. Seventeen least developed countries had been given such support with a view to rationalizing the use of resources for primary health care and mobilizing new resources for that purpose.

It was out of its deep concern for the deteriorating health situation in the least developed countries that the Executive Board had submitted the draft resolution for consideration by the Assembly.

The draft resolution recommended by the Executive Board in resolution EB75.R14 was approved.1

The CHAIRMAN said that a draft resolution concerning the repercussions on health of economic and political sanctions between States had been submitted by the delegations of Argentina, Bolivia, Cuba, Guyana, Lao People's Democratic Republic, Mexico, Mozambique, Nicaragua, Seychelles, United Republic of Tanzania, Vanuatu, Viet Nam and Zaire. The delegations of Bulgaria, Czechoslovakia, Democratic People's Republic of Korea, German Democratic Republic, Hungary, Mongolia, Poland and the Union of Soviet Socialist Republics had also indicated their wish to become co-sponsors. The draft resolution read as follows:

The Thirty-eighth World Health Assembly,

Bearing in mind the principle set out in the WHO Constitution that the health of all peoples is fundamental to the attainment of peace and security;
Reaffirming that resolution 2625 (XXV) of the United Nations General Assembly concerning friendly relations and cooperation among States remains fully applicable to the solution of the problems facing countries;
Recalling resolution 39/210 of the United Nations General Assembly deploring the fact that some developed countries continue to apply economic measures that have the purpose of exerting political coercion on the sovereign decisions of developing countries, and reaffirming that developed countries should refrain from threatening or applying trade restrictions, blockades, embargos and other sanctions;
Bearing in mind that the efforts of Member States to improve the health of their peoples may be seriously affected by the application of coercive economic, commercial or political measures by other countries;

1. REITERATES the basic principles regarding the happiness, harmonious relations and security of all peoples, as set out in the WHO Constitution;
2. EXPRESSES its concern that political or economic differences between countries may give rise to actions that obstruct the attainment of the fundamental aims of WHO and prejudice the development of the health programmes of any Member State;
3. DEPLORES the application by any country of measures of this kind against any other country or countries;
4. URGES all Member States to refrain from adopting measures of this kind and to put an end to those currently in force;
5. REQUESTS WHO Member States to maintain and increase their collaboration with countries affected in this way;
6. REQUESTS the Director-General to keep the worldwide situation in this respect under constant review and to take the necessary steps to ensure that WHO collaborates in preventing and offsetting the unfavourable effects on health.

1 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA38.16.
Dr KOOP (United States of America) said that the draft resolution had been initiated by the delegation of Nicaragua and related to the United States embargo on trade with Nicaragua. The names of the United States of America and Nicaragua had been deleted from earlier versions of the text, but it was clear to all what the draft resolution was about.

It must certainly be acknowledged that the United States of America had serious political differences with Nicaragua. The issue surrounding the draft resolution had dominated much of the discussion in the corridors of the current World Health Assembly and he could not deny that the embargo was a question of some public controversy. A number of governments had issued statements opposing the embargo.

The question to be asked was what the World Health Organization had to do with trade embargos or with the settlement of strong political differences between two Member States. Almost any political issue could of course be stated in terms of its impact on health and it had been alleged that the embargo on trade would cause damage to health. There was no evidence to support such an allegation, which was not consistent with the facts of the United States embargo on trade with Nicaragua. One section of the regulations which had been issued under the embargo was to the effect that "donated articles, such as food, clothing and medicine" were not covered by the embargo when they were "intended to be used to relieve human suffering". A further section stated that "commercial exports to Nicaragua of medicines and supplies intended strictly for medical purposes were authorized". There was accordingly no merit to the allegation about damage to health.

The question therefore might well be asked why such a draft resolution had been submitted to the Committee. Even supposing that the embargo had affected exports of medicines and supplies - and it had not done so - it might be asked what responsibility WHO had for trade between nations or for the settlement of political disputes. It would be misleading to pretend that WHO had powers and responsibilities which it did not have. On more than one occasion the Director-General had warned that the constant injection into the World Health Assembly of extraneous political issues would cause lasting damage to the Organization. WHO would be held in little respect if the Health Assembly continued to provide a forum for every little quarrel that might arise, or tried to settle complex matters of international trade or allowed itself to be used by one party or another to bilateral political disputes, instead of discussing very relevant issues such as communicable diseases, immunization, maternal and child health and the budget for 1986-1987. There were appropriate places in the United Nations system where political questions could be addressed and the issue of the United States embargo on trade with Nicaragua had in fact been taken up only a few days earlier by the United Nations Security Council, which was the appropriate forum. There was no point to WHO's discussing the issue; no documentation had been distributed; there was no report by the Director-General; and there were no real details that delegates could discuss. The most that the Committee could do would be to improvize arguments based on minimum facts. That would not be fair to Member States or to WHO.

He therefore hoped that the sponsors would not insist on a vote on such an irrelevant text. If, however, they were not prepared to withdraw the text, he would move the closure of the debate so that the Committee could proceed with the health business of the Assembly.

The CHAIRMAN asked whether any of the sponsors wished to withdraw the draft resolution.

Dr ZAPATA (Nicaragua) said that the draft resolution did not refer to any specific State by name. It had been submitted consistent with the basic principles laid down in the preamble to the Constitution of the World Health Organization to the effect 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; that the achievement of any State in the promotion and protection of health was of value to all; and that unequal development in different countries in the promotion of health and control of disease, especially communicable disease, was a common danger.

The draft resolution was also consistent with the Charter of the United Nations, with the duty of States not to intervene in the internal affairs of other States, with the principle that no State should employ economic, political or any other measures as a means of preventing another State from exercising its sovereign rights and with resolution 39/210 of the United Nations General Assembly.

The CHAIRMAN said that he assumed that the delegation of Nicaragua did not wish to withdraw the draft resolution. There was a motion before the Committee to close the debate on the item under discussion. In accordance with Rule 63 of the Rules of Procedure, if a request was made for permission to speak against closure, it might be accorded to no more than two speakers, after which the motion should be immediately put to the vote. If the Committee decided in favour of closure, the debate would be declared closed. The Committee would thereafter vote only on the one or more proposals moved before the closure.
The delegate of Nicaragua therefore had the right to speak against closure if he so wished.

Dr ZAPATA (Nicaragua) confirmed that his delegation did not wish the draft resolution to be withdrawn.

The CHAIRMAN invited the Committee to vote on the motion for closure of the debate.

The motion was rejected by 38 votes to 13, with 37 abstentions.

Mrs NASCIMBENE DE DUMONT (Argentina) said that her delegation could not accept the use of economic measures as a form of political coercion because that was incompatible with the provisions of the United Nations Charter and contravened multilateral obligations. That view had traditionally been held by Argentina not only when economic sanctions had been unilaterally applied against it but also whenever such sanctions had been used against a developing country. The improvement of primary health care for all the peoples of the world required the strengthening of international cooperation. For that reason she considered that the Health Assembly, with all the moral authority at its disposal, should appeal to all Member States to refrain from any action liable to endanger international cooperation and jeopardize the work of the Organization.

Mrs LUETTGEN DE LECHUGA (Cuba) said that the revolutionary process begun in Nicaragua some six years previously had been an example to all. Nicaragua was a small country, one of the poorest in the world, but determined to live with dignity and maintain its independence. A trade blockade had been imposed on it in an attempt to reduce its freedom and self-determination. By isolating the Nicaraguan revolution it was hoped to stifle the will to independence of Latin America. The economic sanctions were bound to cause suffering and privation to Nicaragua and would have serious effects on all sectors, including health. The time had come to put an end to sanctions and defend the right of weak nations to resist such action. The trade embargo against Nicaragua was absurd and irrational, and violated the principles guaranteeing freedom of international trade. A great power was exerting pressure on a small country struggling to provide medical care to all its people who had been deprived of medical services for decades by tyrannical governments. She called on all countries to demand that the blockade be removed. Her own country had suffered a partial blockade imposed on 3 February 1962 which had exempted medicines and food but had been transformed into a complete blockade on 14 May 1964. The Latin American countries must remain alert since they never knew when their turn might come. By opposing the application of sanctions against Nicaragua the Health Assembly would be contributing to its goal of health for all by the year 2000 and demonstrating its belief in the best traditions of international justice.

Dr QUIJANO (Mexico) endorsed the Argentine delegate's remarks. Trade embargos should be discussed in the Health Assembly because it was clear that such an embargo had an effect on the health of the population.

Mr CHAUHAN (India), supporting the draft resolution, said that his delegation wished to be included in the list of co-sponsors. Economic pressures should not be used against developing countries as a means of political coercion. The use of trade embargos and other coercive measures against a developing country was a particularly dangerous precedent and undermined the entire basis of international cooperation. In that connection, the Ninth Meeting of Ministers of Health of Non-aligned and other Developing Countries had strongly condemned the recent imposition of a trade embargo against one of its participating countries and had urged its speedy removal. The application of a trade embargo against a developing country was bound to have an adverse effect on the health sector and on the availability of supplies, equipment and the services necessary for implementing its strategy of health for all. He therefore urged WHO and Member States to do everything possible to ensure that the adverse effects of a trade embargo were minimized.

Miss ILIC (Yugoslavia) said that her delegation wished to be a co-sponsor of the draft resolution.

Professor MENCHACA (Cuba) said that it was unrealistic and absurd to argue, as the United States delegate had done, that the trade embargo would have no effect on the health situation in a certain country. Were not fuel and food, for example, and spare parts of great importance to health? His country's own experience had shown that a trade embargo could begin in a small way but later be extended to cover everything. To argue that health was not affected was an insult to the intelligence of delegates.
The CHAIRMAN invited the Committee to vote on the draft resolution.

The draft resolution was approved by 59 votes to 2, with 35 abstentions.¹

Mr DE BURGER (Canada) said that his delegation had abstained in the vote on the draft resolution because it considered that the Health Assembly was not the appropriate forum for discussing the matter, which had a tenuous relation, at best, to the Organization's mandate, and the draft resolution's concerns were clearly political rather than technical.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) said that his delegation had voted against the draft resolution because its central theme was outside the competence of the Health Assembly and raised issues which it did not believe could be authoritatively discussed in such a forum. The third preambular paragraph of the draft resolution referred to a resolution adopted by the United Nations General Assembly at its thirty-ninth session which the United Kingdom had opposed for the reasons it had given at the time. Operative paragraphs 3 and 4 of the draft resolution called on the Health Assembly to express a view on issues well beyond its competence. The requests contained in operative paragraphs 5 and 6, and the resources which would consequently be allocated if those paragraphs were adopted, would be better directed in his view to what the Assembly as a whole perceived as genuine health needs.

Mrs CHEN Haihua (China) said that her delegation had voted in favour of the draft resolution because it had always maintained that disputes among States should be settled on the basis of peaceful international relations according to the principle of equality. Her country was against intervention in the internal affairs of any country and opposed to any form of pressure.

Mr LOPEZ DE CHICHERI (Spain) said that his delegation had voted in favour of the draft resolution although it had some doubts about the advisability of dealing with a subject of that nature in the Health Assembly. In addition, he expressed his delegation's reservations with regard to the third preambular paragraph. He considered that all States were required not to adopt the type of measures referred to in the draft resolution as a means of political coercion against developed or developing countries. All nations, developed or developing, should abstain from the threat or application of trade restrictions, blockades, embargos and other similar actions. His Government considered that such measures could be harmful to the health of peoples.

Mr CAMPBELL (Australia) said that his delegation had abstained in the vote on the draft resolution. That should not be taken as a reflection of any particular difficulty with the thrust of the text; Australia's recent vote in the United Nations Security Council should leave no doubt as to that. His delegation was concerned, rather, with certain drafting aspects of the draft resolution, the relevance of the text as a whole to the work of WHO, and its firm view that the specialized agencies were not the appropriate forums for consideration of essentially political issues. The charges contained in the third preambular paragraph of the draft resolution were unacceptable and the language used in operative paragraphs 3, 4 and 5 was highly tendentious and generalized. Furthermore, in the absence of a clear nexus between the application of political and economic sanctions and the adverse effects on medical and humanitarian supplies, he had real doubts as to the relevance of the draft resolution to the important technical work of WHO.

Mr UTHEIM (Norway) said that his delegation had abstained in the vote because the Norwegian Government considered that the draft resolution contained elements of a political nature that did not fall within the field of competence of WHO and should therefore be dealt with in other, competent United Nations forums.

Miss RIDDELL (New Zealand), explaining her delegation's abstention in the vote on the draft resolution, said that the resolution raised the broad issue of the appropriateness and value of sanctions - a subject that had long been a matter of contention and dispute. New Zealand's stance on the question had been clearly expressed by its Prime Minister when he recently stated that New Zealand had long harboured doubts about the efficacy of economic sanctions as a means of promoting political change. Her delegation's position reflected its longstanding concern about political issues of such a nature being addressed in a United Nations body other than the Security Council or the General Assembly.

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA38.17.
Mr ELIAV (Israel) said that his delegation had voted against the draft resolution because it constituted a further example of the regrettable growing politicization of the Organization, another manifestation of which had been directed against his own country that morning. He recalled the moving appeals on the subject that had already been made by the Director-General and by the President of the Health Assembly.

Mr VETTOVAGLIA (Switzerland) said that his delegation too considered that the subject of the draft resolution was not one that fell within the competence of the Organization but should be dealt with in other forums. It had abstained in the vote, because the language used in some parts of the draft resolution was difficult to accept and because it was directed exclusively against the developed countries, thus rendering it somewhat unbalanced. Nevertheless, he stressed that his Government had always, in GATT in particular, opposed the adoption of trade measures of any kind for political ends.

The CHAIRMAN drew attention to a draft resolution on prevention of disability and rehabilitation of the disabled, proposed by the delegations of Belgium, Canada, Egypt, Liberia, Nigeria, Seychelles, Somalia, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania and United States of America, which read as follows:

The Thirty-eighth World Health Assembly, Recalling resolutions WHA19.37 and WHA29.68; Noting the great medical, economic, social and psychological impact caused by disability to millions of people throughout the world; Stressing the importance of the United Nations Decade of Disabled Persons, as underlined in United Nations General Assembly resolution 39/26 concerning the Decade;

1. CALLS ON Member States:
   (1) to emphasize the prevention of disability by achieving the goals of the Expanded Programme on Immunization and by strengthening environmental, occupational and other health programmes;
   (2) to increase opportunities for the participation of disabled persons in social, cultural, religious, recreational and community life, and in decision-making at all levels;
   (3) to expand education, training and job opportunities for disabled persons;
   (4) to facilitate the increased acceptance of disabled persons through communication and education programmes for the general population;
   (5) to increase public awareness and education so as to prevent disabling accidents at home, at work, and on the road;
   (6) to remove all barriers, whether relating to architecture, transportation, communications or legal considerations, in order to permit disabled persons to participate fully and enjoy equality of opportunity;

2. REQUESTS the Director-General:
   (1) to intensify his efforts to publicize the Decade and the goals of the World Programme of Action concerning Disabled Persons;
   (2) to support government efforts to prevent disabling diseases and conditions, giving special priority to achieving the goals of the Expanded Programme on Immunization by 1990, in view of the short-term impact in reducing disability to be expected from the decrease in poliomyelitis alone and the potential for eventual elimination of this disease, and to support governments in improving environmental, occupational and other health programmes;
   (3) within existing resources or with voluntary contributions, to support governments in expanding community-based rehabilitation services and self-help programmes involving disabled persons and their families;
   (4) to ensure that WHO, at both headquarters and regional offices, removes barriers in order to permit full participation and provide equal opportunity for all persons, including the disabled.

Dr KOOP (United States of America), introducing the draft resolution, said that according to the latest analysis 7% to 10% of the world’s population was disabled. The declaration by the United Nations of the International Year of Disabled Persons in 1980 and the designation of the United Nations Decade of Disabled Persons for the period 1982-1992 had resulted in a greater awareness of the issues relating to disability and rehabilitation. However, the situation of disabled persons had not yet changed significantly. In many countries, only 1% to 2% of the disabled population had access to rehabilitation services and
The importance of disability prevention and rehabilitation as integral components of health and social services within primary health care and their consistency with the goals of health for all could not be overstated. In that regard, he was pleased to note that the Pan American Health Organization had set (as part of the Expanded Programme on Immunization) the target of elimination of poliomyelitis in the Region of the Americas by the year 1990. That was a particularly welcome goal, in the light of the serious, crippling effects of the disease.

Dr NAKAMURA (Japan) said it was clear that great efforts would be required of many Member States in order to give effect to the action called for in the draft resolution. A positive approach would be needed to attain those fundamental targets as far as possible. He strongly supported the draft resolution.

Mr CHAMPENOIS (Belgium) said that his delegation was a co-sponsor of the draft resolution because of its wish to draw particular attention to the prevention of physical and mental disability. Prevention should go hand in hand with active efforts to rehabilitate the disabled through the provision of greater facilities for education, vocational training and employment and by removing social and other obstacles. Disabled people ought to be given equal opportunities and a chance to participate fully.

Mr LO (Senegal), Mr AKRAM (Pakistan) and Mr MOHAMMAD (Nigeria) asked that their delegations be included as co-sponsors of the draft resolution.

Mr CHAUHAN (India) said that his delegation could support the draft resolution but considered that the action it proposed should be fully integrated into the overall strategy for health for all by the year 2000 and should also be fully coordinated with the efforts being made by other agencies. To that end, he proposed that a further preambular paragraph be added to read:

Stressing the need to integrate fully activities for the prevention of disability and rehabilitation of the disabled within the framework of the strategies for health for all by the year 2000;

and that two further subparagraphs should be added to operative paragraph 2 to read as follows:

(5) to ensure that WHO's programmes for prevention of disability and rehabilitation of the disabled are integrated fully with the implementation of the strategies for health for all by the year 2000;

(6) to intensify WHO's collaboration and coordination with other concerned agencies and voluntary bodies in programmes aimed at prevention of disability and rehabilitation of the disabled.

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 OWEIS (Jordan), rising to a point of order, drew attention to Rules 50 and 51 of the Rules of Procedure, which covered formal proposals related to items of the agenda. He submitted that the draft resolution bore no relation to agenda item 33.1 under which it had been tabled, nor did it deal with issues that fell within the competence of the Health Assembly or its committees. There were other forums, such as the United Nations Security Council and General Assembly, to deal with such questions. At the Thirty-seventh World Health Assembly, an attempt had been made to propose a similar draft resolution which had been refused consideration by the plenary meeting and by Committee B. He therefore submitted that the draft resolution was not receivable in Committee B.

The CHAIRMAN invited the Committee, in keeping with the precedent established at the Thirty-seventh World Health Assembly and in accordance with the Rules of Procedure, to vote on the receivability of the draft resolution.

By 21 votes to 13, with 54 abstentions, the Committee decided that the draft resolution was not receivable.

1 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA38.18.
Mr SHAHABI SIRJANI (Islamic Republic of Iran), in explanation of his vote, said that concern for the preservation of health as a whole and its promotion to the highest possible level throughout the world had been the noble aim that had led to the birth of the World Health Organization and of the Health Assembly. About 20 years previously, attention had been focused on the health aspects of the use of chemical and bacteriological weapons. In 1967, the Twentieth World Health Assembly had adopted resolution WHA20.54 in which it welcomed United Nations General Assembly resolution 2162(XXI) and called upon all Member States of WHO to make every effort to comply with it. In response to a request to the Director-General from the United Nations Secretary-General to cooperate with the United Nations in the preparation of a report on the subject, WHO had, in 1970, issued a report on the health aspects of chemical and bacteriological weapons. That report had emphasized that chemical and bacteriological weapons posed a special threat to civilians and that the large-scale use of such weapons could also cause lasting changes of an unpredictable nature in the human environment, since their possible effects were subject to a high degree of uncertainty and unpredictability. It had also noted that its conclusions were in harmony with the conclusions of the United Nations Group of Experts on Chemical and Bacteriological (Biological) Weapons and expressed the hope that further action would be taken to deal with the threat posed by the existence of such weapons. That hope had been expressed 15 years previously. Today the threat was not limited to the existence of chemical and biological weapons; they were actually being used, for example against the Iranian forces, as had been confirmed by the United Nations expert mission that had visited the war fronts in the Islamic Republic of Iran. A statement by the United Nations Security Council in March 1984 had confirmed the findings of that expert mission.

Mr MAHBOUB (Iraq), rising to a point of order, said that discussion on the subject of the draft resolution was out of order in view of the vote just taken by the Committee.

The CHAIRMAN requested the delegate of the Islamic Republic of Iran to confine his statement to the explanation of his vote.

Mr SHAHABI SIRJANI (Islamic Republic of Iran) said the interruption by the delegate of Iraq had not surprised him. However, he had at no time in his statement mentioned Iraq by name; Iraq's intervention was therefore a tacit admission of its use of chemical weapons.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland), explaining his delegation's vote, said that the United Kingdom, as it had made clear many time in the past, strongly condemned the use of chemical weapons, which was contrary to the relevant international instruments and international behaviour in armed conflict. The United Kingdom would continue to work strenuously for a total ban of such weapons; his Government had recently put forward new proposals to that end at the Disarmament Conference in Geneva. However, his Government did not regard WHO as the appropriate United Nations body to consider disarmament or political matters. It was on those grounds that his delegation had abstained on the question of the admissibility of the draft resolution.

The meeting rose at 17h25.
SEVENTH MEETING

Wednesday, 15 May 1985, at 9h00

Chairman: Mr R. ROCHON (Canada)

1. THIRD REPORT OF COMMITTEE B (Document A38/33)

Dr JAKAB (Hungary), Rapporteur, introduced the draft third report of Committee B. The report was adopted (see document WHA38/1985/REC/2).

2. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM: Item 33 of the Agenda (continued)

Women, health and development: Item 33.2 of the Agenda (Documents EB75/1985/REC/1, resolution EB75.R15, and A38/121)

The CHAIRMAN drew attention to the amendments proposed by the delegations of Finland, France, Norway, Sweden and Switzerland to the draft resolution recommended in resolution EB75.R15. With those amendments (underlined), the resolution would read as follows:

The Thirty-eighth World Health Assembly,

Taking note of the report of the Director-General and of the views of the Executive Board on the health situation of women and their role in health and development, and particularly in the implementation of the Global Strategy for Health for All by the Year 2000;

Noting the close relationship between equal rights for men and women and the participation of women in health activities and in the promotion of health for all, particularly as decision-makers;

Recalling previous resolutions of the Health Assembly on the role of women and, in particular, resolutions WHA28.40, WHA29.43 and WHA36.21;

Recognizing the great importance of the forthcoming World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace;

Concerned at the slow progress made by a number of countries in realizing the objectives of the United Nations Decade for Women, which are formulated in the reports of the World Conference of the International Women's Year, Mexico City (1975) and the World Conference of the United Nations Decade for Women, Copenhagen (1980), particularly with regard to women's health but also with regard to their social security and the safeguarding of their rights;

Concerned at the very high maternal mortality rates in many countries and at the frequency and severity of the repercussions on women's health of certain practices, particularly during pregnancy or childbirth but also during puberty or childhood;

Concerned at the adverse effects on women's health and the risks for their children produced by inadequate conditions of domestic work or paid employment;

Concerned at the frequency of nutritional anaemia in many countries, especially among pregnant women;

Bearing in mind with anxiety the prevalence in some countries of adolescent marriages and pregnancies;

Aware that in some countries the general public does not know enough about the nature of the risk to the health or even the life of women presented by such factors as deficient or inadequate diet, lack of hygiene, excessive workloads and pregnancy prior

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to full physical maturity and corresponding mental development, risks that may also have repercussions on the health of the children;

Recalling the correlation between the education of mothers and the reduction of child mortality levels;

1. THANKS the Director-General for his report to the Executive Board;

2. CALLS UPON Member States to show greater concern, within the context of national activities and international cooperation, for the protection of women's health, particularly as regards the nutrition of women, the health of pregnant women and young mothers and conditions of work; to assist women to carry out their functions as providers of primary health care; to strengthen their efforts to provide women with greater opportunities to pursue activities in the context of the realization of the objectives of the strategies for health for all; and to take an active part in the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women;

3. REQUESTS the Director-General:

   (1) to ensure the Organization's active participation in the World Conference and to present to it a report on the role of women in health and development, on the principal risks threatening women and on the possibilities of guarding against those risks;

   (2) to continue to pay close attention to cooperation with Member States in their activities to promote women's health including information and education of the public, to intensify the participation of women, particularly as decision-makers, in health and socioeconomic development, and to assist them to evaluate the effect of health development programmes and social services on the situation of women and on the protection and promotion of women's health;

   (3) to evaluate the contribution made by WHO's programmes to the promotion and protection of women's health and effects of these programmes on the participation of women in health activities;

   (4) to report periodically to the Executive Board and the Health Assembly on the progress achieved in this field.

He also drew attention to an amendment proposed by the delegation of France to the same draft resolution, which would consist of inserting in operative paragraph 3 a new subparagraph (3), to read as follows:

   (3) to strengthen coordination with the other United Nations agencies that pay special attention to the economic role of women.

The other subparagraphs would be renumbered accordingly. He suggested that the resolution in its amended form be used as a basis for discussion.

Dr HAPSARA (representative of the Executive Board) said the Director-General had reported to the seventy-fifth session of the Board as a follow-up to resolutions WHA28.40, WHA29.83 and WHA36.21; on the occasion of the ending of the United Nations Decade for Women; and on the 1985 World Conference. That report was annexed to document A38/12.

It reviewed the situation regarding women, health and development, noted the crucial importance of women in the context of the goals and strategies for health for all, and defined their health needs especially in relation to their child-bearing and child-rearing roles. It outlined some of the ways in which women contributed to development, and the key roles that they played in health care in the family and the community, often under difficult conditions. It stressed that the goals and principles of the Decade for Women, particularly in regard to health, were essentially the same as the goals and principles of health for all.

Action being taken, especially at country level, both to benefit women's health and to encourage their participation in development, included information support and transfer, primary health care, social support measures, support for women's organizations, and encouragement of women as health care providers, as well as intersectoral activities in the areas of food and nutrition, and water and sanitation. A number of key obstacles had to be overcome if full equity for women in health and development was to be achieved, and the report concluded by proposing strategies.

The report had been well received by the Board, and had given rise to a lively discussion. It had been pointed out that progress over the past ten years had consisted more in the recognition of the problems facing women in health and development than in concrete
action to solve those problems. The Board had urged that efforts should be made to improve the acceptability and accessibility of health care for women, to have more women as decision-makers in the health field, and to bring women more into the mainstream of development. The Board had also agreed that it was important to include an assessment of the health and social status of women in the monitoring processes for health for all, not only as a means of evaluating progress, but also as a means of identifying key obstacles to more effective action.

He said that he could fully endorse the amended version of the resolution recommended in resolution EB75.R15 that had just been introduced by the Chairman.

Dr CORNAZ (Switzerland) said that three aspects should be taken into account when considering the situation of women in relation to health; the first two were dealt with in the Board's original draft resolution, and the third was dealt with in the amendments to it proposed by the delegations of Finland, France, Norway, Sweden and Switzerland.

The first aspect was the link between a family's socioeconomic situation and its health status. For example, in disadvantaged or vulnerable population groups, child mortality and morbidity decreased as the education of women improved. In the same population groups, an increase in the income of women usually led to improvements in the standard of nourishment of the family, and above all, of the children, on condition that it was the women's income, or shared family income, rather then income solely of the husband, that was involved. Those findings were the result of independent studies carried out in different regions. That general link between the situation of women and their contribution to development would be the theme of the Nairobi Conference on the Decade for Women, and it was appropriate that the Organization was being urged to participate in that conference.

The second aspect, which was clearly brought out in the Director-General's report, was the contribution made by women to health protection and promotion, both informally in their own families or communities and on a formal basis as health personnel. Here, too, the resolution urged Member States not only to give due attention to the importance of that contribution but also to assist women to play that essential and irreplaceable role.

The third aspect concerned the health risks to which women were exposed, risks of which the public was too often unaware or which were accepted as inevitable; scant allusion had been made to those risks in the Board's original resolution. Every year some 500,000 women died in childbirth or following childbirth, for reasons which could have been avoided. In many countries two women out of three were anaemic, not necessarily as a result of poverty but rather as a result of certain dietary habits; that constituted a real danger in the case of pregnant women. Such a high proportion of pregnant women were at risk that priority attention should be given to the problem. The other risks to women's health that were indicated in the report were likewise sufficiently important for the public to be made aware of them; not only health authorities but also families, employers, and training institutions should take action to make them more widely known. The chief object of the amended resolution was to increase awareness of the three aspects she had outlined.

Another important point which had been introduced in the amended resolution was evaluation of the effects of WHO's programmes both on women's health and on their potential for contributing to health promotion. In fact, experience had shown that such programmes did not automatically have a positive effect, and evaluation should make it possible to see what improvements should be made and what were the dangers to be avoided.

Although her delegation had unfortunately not been able to consult all other interested delegations in the preparation of the amendments, she hoped that they would give their support to the amended resolution, which aimed to give better protection to women's health as well as to enable women to play their full role in health promotion.

Dr KOOP (United States of America) agreed that women's health problems and the role that women played in the provision of health care must be seen as an integral part of the health needs of the population and could not be seen in isolation. Women's health would not significantly improve unless they were actively involved, and a less than healthy mother and wife would not have a healthy family.

The role of women in caring for the health needs of children was so obvious as to require no further comment. The responsibility for mixing oral rehydration solutions, for assuring sound nutrition and clean water, for adhering to immunization schedules and, in many countries, for providing for all the basic human needs was placed firmly on women. Moreover, studies confirmed that a literate and healthy mother was better able to accept such responsibility.

In 1984 the United States Public Health Service had established a task force on women's health issues to ensure that the health needs of women were effectively provided for. The Task Force had investigated women's health problems associated with each of the life stages, had identified areas requiring special attention, and had recommended priorities for
programmes to solve those problems. Subjects had ranged from social factors affecting women's health to issues related to mental health, including alcoholism and drug abuse, and the special health concerns of older women. The work of the Task Force was completed, but efforts to cater for the health needs of women and to implement the Task Force's recommendations would continue; a committee had been established to keep matters under review.

The role of women in society, especially in the economy, could not be overlooked. In paragraphs 42 and 43 of the Director-General's report it was indicated that two-thirds of total working hours were worked by women, who also accounted for at least 50% of food production. Thus it was evident that women had a vital role to play in the socioeconomic development of the community, in the health care of the family, and in the improvement of the health status of the nation, as well as in activities designed to promote health for all.

While women had always played the key role in health care as mothers, wives, teachers and health providers, traditionally health leaders and health decision-makers had been mostly men. Women were not normally given serious consideration for high positions, often for reasons rooted in prejudice. Societies, however, were changing and women were ready to respond to the demands of changing circumstances. Women throughout the world were making significant contributions to the health and socioeconomic development of their countries and were involved in activities which a few years earlier would have been unthinkable or would have been considered the prerogative of men. It was the responsibility of everyone to ensure that women received equal treatment and opportunity in the management and leadership of health activities. His delegation believed that WHO should pave the way by actively encouraging the hiring, promotion and involvement of women in all its activities at the global, regional and country levels.

The forthcoming World Conference in Nairobi would be of great significance in that it would provide an opportunity for national officials to chart a realistic course for the future. The United States of America were committed to action to improve the status of women throughout the world, especially in developing countries, and he urged the Director-General to ensure that WHO played an active part.

His delegation's uppermost concern for both present and future action was that all sectors of society should be encouraged to utilize the services of women in leadership positions of all types and at all levels. In particular, it would like to see WHO take the lead in promoting action in support of Member States to ensure that women had improved access to resources, training and new technology, especially for basic human needs such as food, water and health care, as well as an opportunity for increased participation in economic activity. His delegation believed that WHO had an essential role to play in promoting action both within the Organization and on a worldwide scale to ensure that concerns specific to women were approached on an integrated basis in all areas of health policy and planning.

Finally, his delegation supported the draft resolution before the Committee and urged the Director-General to accelerate the implementation of measures to promote the active participation of women, particularly as decision-makers, in health and socioeconomic development.

Dr KEAN (Australia) said that his delegation strongly endorsed the Director-General's report to the Executive Board, which was relevant to many Australian women, particularly aboriginal women and women living in remote areas. Points made in the report which required to be particularly emphasized included the need for better data collection, the need to support and collaborate with WHO programmes, and the need to support international and national nongovernmental organizations working in the area under review. However, in connection with the forward-looking strategies outlined in the report, serious consideration had to be given to the political willingness of men to share power and of governments to implement the recommended strategies.

An increasing number of women in the Australian workforce were afflicted by the condition known as "repetition strain injury", a term used to describe a collection of disorders found largely but not exclusively in workers who were constantly required to perform rapid repetitive movements of parts of the upper limbs - for example, keyboard operators, especially those associated with automated data entry and word-processing. In many cases the condition assumed such severe proportions that the sufferer had to leave the workforce permanently. Australia would be pleased to share its experience of the condition with other countries.

Dr SUDSUHK (Thailand) said that his delegation recognized the crucial importance of the topic; he stressed that the associated problems were largely specific, not to regions, but to individual countries: within one and the same country women's status and potential for participation in development activities differed according to geographical, socioeconomic, religious and cultural circumstances. Consideration should therefore be given to the
elaboration of a very broad global policy framework and of broad regional policy frameworks to accommodate national policies, strategies and plans of action taking into account the diverse circumstances in which the women of a particular country found themselves.

The overall objective was to ensure that women progressively obtained equality with men as far as their participation in national development activities and enjoyment of various developmental services were concerned; it would not be very productive to promote women's role in development separately: women and men should work side by side at every level.

There was no doubt that women must be accorded special consideration as recipients of health care. They could and should also play a major role as health care providers, not only as members of the various health professions but also as prominent members of the community. In fact, health appeared to be an excellent starting point for promoting the equality of women with men in all aspects of national development, including decision-making and the development of primary health care services at the community level. They could become involved in village development councils, in Thailand, or similar grass-root bodies in other countries.

His delegation supported the amended draft resolution.

Mrs HERZOG (Israel), speaking also on behalf of the International Council of Women, congratulated the Director-General on his report. WHO had helped to create the awareness that women's health and women's role in society were interdependent, and had recognized that health for all could be achieved only if men and women were involved in the development processes on a footing of equality. The complexities of the problems faced in different populations were reflected in the report, which not only analysed the issues but also suggested strategies and monitoring systems. A number of indicators had been proposed for assessing the status of women; perhaps the most significant, even though it might be the least measurable, was society's perception of women's role within the family, the community and the social structure.

Paragraph 117 of the report contained a reference to the need for measures to prevent the abuse of women's bodies through violence, sexual exploitation and sexual mutilation. Perhaps a further reference should be made to the need to prevent the worldwide exploitation, in advertisements, of nude or partially nude female bodies matched with lifeless and expressionless faces representing nothing more than a sex object, usually in a position inviting sexual violence. She wondered whether adequate thought had been given to the damaging effects of such advertisements on the young and suggested that the Committee should join in the outcry against such practices.

Health legislation was crucial for the attainment of health objectives specific to women. In her country the law provided for a minimum marriage age, for three months' maternity leave on full pay and for a break during working hours to allow nursing mothers to breast-feed their babies. The latter right was afforded to both natural and adoptive mothers, so that their babies could enjoy a hug and a cuddle and a sense of security. There was much room for improvement; for instance, school hours were not long enough, and in a number of areas gaps between the spirit of the law and its implementation still had to be bridged. Nevertheless, there was equal pay for equal work and crèches and kindergartens established by women's voluntary organizations made it possible for women to work full-time in the knowledge that their infants were being properly cared for. An outstanding feature in primary health care was the family health centres which provided the population at large with basic services such as health education, immunizations, family planning facilities, child development guidance, and care for the elderly.

Man and woman were created in the image of God not to compete with one another, but to love and complement one another, sharing the challenges of life to make its burdens lighter. A collaborative spirit of unity was required to help people to help themselves and others. What united mankind far outweighed what divided it, and a genuine dialogue transcending political diatrace would promote mutual understanding and make the world a better and healthier place for the younger generation.

She hoped that the draft resolution before the Committee would be approved unanimously.

Mrs RUMJANEK CHAVES (Brazil) said that her Government was aware of the scope of the role of women in health and socioeconomic development and of the related problems. Women's increasing participation in Brazil's development had led to a search for an integrated solution, which in turn had led to the need to comply with the demands in the areas of employment, health and education. The Government had sought to improve its employment legislation through the ratification and implementation of measures strictly related to women's rights to protection and safe working conditions. It had also adopted ILO Conventions No. 45 on women on underground work, No. 89 on nightwork, No. 103 on maternity protection and No. 111 on discrimination in employment and occupation. In 1981 Brazil had

The access of women to basic education and to universities had greatly increased in recent years, and in some universities women already outnumbered men.

The health of women was a high government priority, and the programme of health assistance for women went beyond their specific reproductive role and provided for all stages in their lives. The Government recognized the importance of intensifying follow-up programmes for maternal and child care, including family planning. In the latter connection, Brazil reaffirmed the fundamental human right to the knowledge of the possibilities of influencing the rhythm of procreation, and the Government intended to provide information and means to enable individuals to plan their families; such assistance would form part of the public health programme and have no demographic goals. Brazil affirmed the validity of the principles upheld by the Population Conference of Bucharest and reaffirmed at the 1984 Population Conference in Mexico. Both conferences had stressed that only socioeconomic development would reduce the consequences of malnutrition, infant mortality and other related problems.

The Government was successfully implementing programmes that directly promoted women's health, including an early cancer detection programme and a national supplementary food programme for women during pregnancy and breast-feeding.

The Director-General's report referred to strategies for the future. The Brazilian Government, within its overall foreign policy, considered that the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women would provide a good opportunity for further effort towards pragmatic international cooperation.

Mrs HAARSTAD (Norway) expressed her delegation's appreciation and support for the Director-General's report.

Throughout the ages women had evolved their own strategies for survival both for themselves and for their families; it was not always obvious that planners and health workers were aware of that when giving practical expression to their concern for women as recipients and providers of health care. Women had often been denied responsibility for their own health. Well-intentioned health workers had contributed to the medicalization of all reproductive functions: there had been health professionals, for example, who had doubted the benefits of breast milk, and it was only in recent years, and with the help of WHO, that breast milk had been deemed not only harmless, but actually best. Other practices common to a majority of female cultures, and based on empirical knowledge, were gradually becoming accepted.

Women were often perceived as a homogeneous group. In fact, women as a group were as heterogeneous as men, with differences in age, stages in reproductive activity, in marital status and status in the family hierarchy. There were differences in their participation in the formal, as opposed to the informal, sectors of the economy. Furthermore, women often constituted the majority of special groups, such as refugees, illiterates, etc. Problems faced by de facto single-parent, female-headed households were tremendous. For a variety of economic, demographic or sociocultural reasons a very considerable proportion of births occurred outside the context of the accepted family unit. In addition to the practical and economic problems of being a single parent, a sense of loss or grief often increased the burden. Illegal abortions were still a major health problem in many countries. All those aspects had serious consequences for the health of women and their families.

Modern technological development had largely been in the hands of men, while women's more traditional technology had been poorly understood. The technology used by women in their daily work often had several purposes, some practical, some social, and the inventor was usually unknown. Outside the health services sector it was perhaps in food production and water supply that overlooking the role of women had the most serious consequences for health. The men in charge of the technology were often more interested in local water politics than in seeing that the water-point worked, and there were parallels in the case of food production. If health was to be improved by efforts to increase food availability, women must be involved and respected as controllers of the improved technology. Women's potential to contribute to the decision-making processes in health development had to be acknowledged.

The economics of the reproductive role as it affected the labour force, both by giving birth to children, and by feeding and maintaining children, youth, adults and the elderly, had not been given much attention. Most of the activities were covered by what the economists labelled the private sector or the informal sector not falling within their terms of reference. There was increasing evidence of the serious effects on the health of women and children of women being encouraged to work in the formal sector for far less than the real value of the child care and food produced by them in the informal sector. Total
productivity also suffered as a result. It was therefore important in health terms to ensure that women were properly paid when employed in the formal sector.

That example was only one specific expression of a general observation: transitional stages in any economy, both in developed and developing countries, affected women more profoundly than men, in the sense of imposing extra, "invisible" burdens upon them, and women had to absorb a considerable proportion of the cost of the changes in the economy.

The time had come to challenge that situation. Social attitudes were obstacles to progress. WHO should raise the question of the role of women in national economic and health development, stressing the need for revised guidelines for national accounting to include women's participation in both the formal and informal sectors of the economy.

If health for all was to be attained each country had to strengthen women's opportunities, giving them greater access to professional training and skill development and increasing their numbers in decision-making positions at all levels of society. WHO must continue to support countries' efforts to improve the educational and employment conditions of women in order to obtain better returns in terms of health and productivity.

WHO should become more actively involved in all stages of the planning of programmes to meet the needs of women, collaborate with women's organizations, and advocate opportunities for women to enter the labour market and earn an income.

The Norwegian delegation strongly supported the strategies proposed by the Director-General in his report to strengthen the efforts already made in that direction. Norway had for that reason co-sponsored the amendments to the draft resolution proposed by the Executive Board.

Dr MAFIAMBA (Cameroon) said that the report had been transmitted in Cameroon to the Ministry for Women's Affairs which had been created in 1984. Women had always played an important role in African society, not only as mothers but also in the socioeconomic and sometimes in the political fields and in national liberation struggles. In Cameroon, since the new President had taken office, the number of women in the Government had increased from two to five, and greater numbers of women were being appointed to responsible positions within the Government, and in teaching and health and other sectors. Cameroon had been one of the countries which with WHO had organized trial health development projects directed by women in village communities.

WHO was to be congratulated on the action it had taken to promote the development of women. His delegation supported the amended draft resolution.

Mr CAO Yonglin (China) said that his delegation appreciated the detailed presentation of and comments on the situation of women, the action taken by WHO, and future strategies, in the Director-General's report. Women were a tremendous force in the promotion of socioeconomic development in the progress of mankind. The United Nations Decade for Women had been important in awakening and strengthening the international communities' awareness of women's problems, in improving the status of women and in increasing the role played by women.

In China, women and children constituted two-thirds of the population. Since the founding of new China in 1949 the status of women had undergone a fundamental change: they now actively participated in political and economic construction, and in all areas enjoyed equal rights with men. Their rights and interests were protected by law: the Constitution of China stipulated that women should enjoy equal rights with men in all areas, political, economic, cultural, social and in family life. As the State protected the legitimate rights and interests of women, men and women received equal pay for equal work, and the State protected marriage, the family and children. In the supreme organ of State power, the National People's Congress, 21.2% of the delegates were women. Apart from 12 women Ministers, there were many women who had senior positions. China also had almost 3.5 million women scientists and technicians, which was 32.8% of the total number. The number of working women in China had increased from 600 000 in 1949 to 41 990 000 in 1983, and constituted 36.5% of the urban workforce. They worked not only in light and textile industries, financing and accounting and the service industries, but were also increasingly working in sophisticated technology sectors. In the oil industry, for example, women made up 30% of the workforce, and in the electronics industry, 40%. Women constituted half the workforce in the rural areas and shared the responsibilities for production.

China had 3 340 000 professional health personnel, of which women accounted for 56.9%, working actively in disease control, family health and maternal and child health care (promoting new delivery methods and family planning), carrying out general surveys and treating different diseases affecting women's health, strengthening labour protection and developing perinatal health care. A three-level maternal and child health care network had already been set up nationwide; there were now 239 maternal and child health care and maternity hospitals, with 21 714 beds, 26 children's hospitals with 6271 beds, and 2716 maternal and child health care centres. Due to employment of vast numbers of women, China's
birth-rate had fallen from 24.9 per thousand in 1974 to 18.6 per thousand in 1983; the infant mortality rate had fallen to 34.68 per thousand in 1983 and the maternal mortality rate to 0.5 per thousand. From 1973 to 1983 the natural population growth rate had fallen from 20.89 per thousand to 11.54 per thousand, and in 1984 it had fallen to 10.81 per thousand.

The Chinese delegation endorsed the national, regional and global strategies presented in the report. It should be recognized that the true liberation of women and improvement of their role were a long-term and arduous task. Efforts had to be made to improve women's educational and technical standards. More and more women had to be able to participate in decision-making in all areas. Their burden of housework should be lightened, and legislation and other measures strengthened so that women could make an even greater contribution to health work and to development.

Mrs LUETTGEN DE LECHUGA (Cuba) said that as stated in the report of the Director-General the situation of women in a society reflected the level of social justice among other factors. Since 1959 the Government of Cuba had adopted a series of legislative and administrative measures to give full equality to the Cuban woman and allow her full participation in the social and economic development of the country. The right to equality was guaranteed by the Constitution, the family code, maternity legislation, and occupational safety and health legislation. The participation of women in employment had increased to 35.1% of the total labour force by 1982, women occupying 22.6% of all managerial positions. Increased responsibility was taken by social services for education and recreation for children and young people and care of the elderly. A survey carried out in 1984 had shown that 42.3% of research workers were women. It was estimated that women would be 45% of the labour force in the year 2000.

In the 1970s the Ministry of Public Health had paid particular attention to the health of women and children under the national health programme through the national programme on infant mortality and the programme on women. Those programmes had been revised in 1980 and integrated in a national maternal and child care programme. Maternal mortality had been reduced from 7.04 per 10 000 live births in 1970 to 4.82 in 1982. There had also been a reduction of infectious and parasitic diseases, from 16.9 per 10 000 inhabitants in 1975 to 11.3 in 1982. The death rate had fallen to 2.0% in 1982, a decrease of 10%. Life expectancy had increased, being 75.2 years for women and 73.5 years for the population as a whole in the period 1980-1985.

In the context of family planning, the Ministry of Public Health had established standards regarding contraception, abortion, sterilization, and sex education and therapy. Women had access to competent services, and parents were able to decide on the number of children and the spacing of births. The programme of sex education, in conjunction with other measures, had proved effective, as witnessed by a decline in overall fertility from 3.7 in 1970 to 1.8 in 1981.

The number of women examined under the programme for uterine and cervical cancer detection had increased from 432 000 in 1975 to nearly 483 000 in 1982.

The Cuban experience and that of other countries eloquently showed that it was possible to put an end to discrimination against women and that women had an important role to play in social development and progress. She requested the Director-General of WHO to submit a report on the role of women and development to the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women, to be held in Nairobi in July 1985.

She supported the draft resolution.

Professor MARTINEZ MARQUEZ (Argentina) congratulated the Director-General on his report. Since 1984, health and social activities to improve the status of women and promote their integration in society had been intensifed in Argentina. In November 1984, a seminar had been held with UNICEF and an inter-American paediatric institute of the Organization of American States to review existing legislation on maternal and child protection, followed in April 1985 by a national meeting to draw up an action programme. Legislation relating to working mothers had been revised. The new legislation gave true equality to women, avoiding protectionism which was often both detrimental and discriminatory. Policies could be divided into (1) legal and administrative measures to eliminate discrimination against women, to provide equality of opportunity, to allow breast-feeding, to reduce working hours, etc.; (2) measures to support women working and studying outside the home, such as child care services and school canteens; and (3) measures to facilitate the return to work of women who had left work for family reasons.

Such equality could only exist in a democracy. Women played an important role in Argentina, not only as mothers and wives, but also in the production of goods and services, especially in health and the social services. The problem in Argentina was no longer one of lack of freedom so much as of the old pride in demonstrations of strength through work, in
which a place had to be made for women in the interests of their health and their role as partners in national development for the future.

He supported WHO's efforts to promote the equality of women; they should be intensified. Argentina supported the draft resolution.

Mrs VAN DRUNEN LITTEL (Netherlands) said that the end of the United Nations Decade for Women offered a good opportunity to look back at policies and achievements. It was, however, only a beginning. With increased understanding of women's problems, the time had come to apply the knowledge gained. The response of WHO to women's concerns was an important contribution. It built on WHO's recent experience, as well as making use of significant research findings, such as the specific health needs of women and the important contribution of women to the health of their families. Research had also shown that women were increasingly faced with greater responsibilities for the cash needs of rural and urban households; 30% to 35% of all households were estimated to have a woman as the head. Moreover, in households where both men and women earned income, the woman would use almost all of her earnings for the household, while a significant proportion of the man's income was frequently spent on articles to enhance his status.

Women had protested against certain harmful traditional practices, such as female circumcision, and they had organized themselves and planned activities to help eliminate such practices. The International Conference on Population held in 1984 had recognized that couples and individuals had the right to decide freely and responsibly on the number and spacing of their children; governments should take measures to ensure that right. Family planning components of primary health care should be strengthened and family planning information and services should be provided.

It was clear that raising the status of women was a major concern for WHO because of its positive effects on the health of the family and on national development. The report by the Director-General gave a good analysis of the situation of women and review of the action undertaken to date. It was encouraging to read that progress had been made in the formulation of policies that had a positive effect on the health of women. Responses of governments to the questionnaire sent out in preparation for the Nairobi Conference showed, for example, that higher priority was being given to maternal and child health and family planning. A number of constraints had, however, been identified as regards the implementation of policies. Key obstacles to progress were the absence of mechanisms for increasing the participation of women in health endeavours at all levels, as well as existing social attitudes towards women. She pointed out that these obstacles also existed within donor agencies and governments. A recent United Nations survey had shown that less than one out of six projects classified as affecting women were actually designed to involve women or to address women's interests, and that a key factor was the persistent failure on the part of those implementing development policies to recognize women's central role in development. The perception, knowledge and orientation of staff members of development agencies was extremely important in the implementation of such policies.

She regretted that the report had not included recommendations to increase the understanding and commitment of staff members. Similar problems had been noted in bilateral assistance programmes carried out by the Netherlands. Many staff members were ignorant of women's needs and did not see how they could differ from those of men. Steps had been taken to narrow the gap between policy and implementation, with strong commitment from higher management and staff training at all levels. Specialized programming assistance, adequate gender-specific data bases and the stricter application of existing guidelines and instructions were other measures which could be applied successfully. WHO might find such measures effective. It might also be necessary for WHO to establish or strengthen coordination and monitoring at all levels. In addition, more personnel and financial resources could be directed to the implementation of national policies on women, health and development.

She suggested further amendments to the draft resolution, to include in the fifth preambular paragraph, after "United Nations Decade for Women, Copenhagen (1980)", a reference to the International Conference on Population, Mexico (1984); to add a new operative paragraph 3 to read:

REQUESTS the Executive Board to monitor the developments in the field of women, health and development;

and renumber the paragraphs accordingly; and to insert in old operative paragraph 3, subparagraph (2), after "their activities", the words "and to provide expertise".

The meeting rose at 10h35.
EIGHTH MEETING
Wednesday, 15 May 1985, at 14h30

Chairman: Mr R. ROCHON (Canada)

COLLABORATION WITHIN THE UNITED NATIONS SYSTEM: Item 33 of the Agenda (continued)

Women, health and development: Item 33.2 of the Agenda (Documents EB75/1985/REC/1, resolution EB75.R15, and A38/121) (continued)

The CHAIRMAN recalled that an amended draft resolution on women, health and development had been read out at the beginning of the seventh meeting and that additional amendments had been submitted by the delegation of the Netherlands. To facilitate discussion, delegations were requested, when expressing support for the amended draft resolution, to indicate whether they supported the additional draft amendments.

Mr KWEN Seung Yeun (Democratic People's Republic of Korea) observed that the Director-General's excellent report (document A38/12) described women's contributions to health and socioeconomic development. After his own country's liberation, one of its socioeconomic development priorities had been to ameliorate the situation of women. An immediately promulgated law on the equality of the sexes had enabled women to participate in all socioeconomic activities on an equal basis with men. Social security had been provided for women and radical measures adopted to improve their medical care. Women were themselves active in socialist construction, particularly in the health field.

His country's experience had shown that it was important to provide legal guarantees to enable women to participate in socioeconomic activities and enjoy special health protection and that the State and society must take the necessary steps to improve medical services for women. Well-regulated medical service systems must be set up and, to that end, appropriate measures should be taken to establish and expand facilities such as maternity hospitals and centres, to which specially trained medical workers must be assigned. He hoped that WHO would take note of those suggestions, the implementation of which would contribute much to the attainment of the goal of health for all by the year 2000.

Miss ILIC (Yugoslavia) observed that the Director-General's report analysed the situation regarding women, health and development; it drew attention to women's special needs and key role in health and development and gave an account of international, regional and national action to enhance women's health and participation in development. It touched on the major obstacles faced by women in achieving full equality in health and development and contained forward-looking strategies for future activities.

Although progress had been made in many areas, the results had fallen far short of the expectations with which the United Nations Decade for Women had begun. The economic crisis had jeopardized the development efforts of the developing countries and had aggravated the difficulties with which the majority of mankind was confronted. As a result of their decreased ability to implement their development plans, expenditure by developing countries for education, health and social services had dropped. The combined effects of higher inflation, lack of employment opportunities and restrictions on investment in child care institutions had increased the economic burden on women and reduced the role they could play in development and decision-making.

The role of women in development had a bearing on every one of the world's pressing problems, and none of those problems could be fully resolved unless the unjust international economic order was modified. The non-aligned countries, including her own, attached great importance to improving the status of women and ensuring their active participation in all spheres of life. They had adopted a medium-term programme of technical cooperation among developing countries for health for all for the period 1984-1989, and had recently devoted a

While almost everyone recognized of women's role in development, suggesting measures to be undertaken by non-aligned and other developing countries at all levels to improve the status of women.

Confident that social development and economic policies must be integrated and actively committed to improving the quality of life, her delegation believed that to achieve those goals, careful planning and the mobilization of all resources, including human ones, was necessary and should be accompanied by the coordination of activities at all levels. WHO would have a major role to play in that field in years to come.

Mrs OLASZ (Hungary) thanked the Director-General for his report, which painted a picture of women, health and development as complex and contradictory as the modern world itself. While almost everyone recognized that women played a fundamental role in economic and social life, including health care and its improvement, ways of facilitating their fulfilment of that role were still largely lacking in many countries. Certainly, a decade was not sufficient to break down walls which had been standing for thousands of years or to eradicate established traditions which hindered women from achieving equality with men. Even in her country, whose legislation had ensured equality of rights and opportunities for women for the past 40 years, the situation was far from satisfactory. Despite various forms of State support and benefits, working mothers continued to bear primary responsibility for caring for children, the elderly and the sick. While they did so willingly, they were often thereby disadvantaged as far as professional training and advancement were concerned, their interests being sacrificed to those of the family. The time had surely come for public opinion and traditional views about the role of women in modern society to be changed.

As the report pointed out (paragraphs 71, 83 and 84), Hungary had cooperated successfully with WHO in activities relating to women, health and development and would continue to do so in the future.

In conclusion, she said that the Hungarian delegation supported the draft resolution recommended by the Executive Board in resolution EB75.R15.

Mr SOKOLOV (Union of Soviet Socialist Republics) said that the Director-General's well-prepared and comprehensive report adequately reflected the state of participation of women in development efforts and health care. The plans for the future contained therein had been developed with a view to implementation at the state, regional and global level, were closely linked to health-for-all activities and fell within the context of the primary health care strategy as defined at the Alma-Ata Conference in 1978. For all of those reasons, his delegation welcomed and supported them.

The United Nations Decade for Women would end in 1985 and the degree to which its goals had been achieved would be assessed. The difficulties encountered by developing countries in that regard could not be overcome easily or quickly, and Member States of WHO must make sustained efforts if they desired success.

In the Soviet Union, women enjoyed equal rights with men in all fields of human endeavour. They were elected to the highest legislative bodies side by side with men and participated on an equal basis in political organizations and economic activities. Under the Soviet system of medical coverage, women received every form of medical care they needed, free of charge. They played an outstanding role in the Soviet health care system as doctors and medical workers.

The Soviet delegation supported the draft resolution as presented.

Dr GLASS (Canada) said that the Director-General's report pinpointed many problems and sought to address all aspects of the subject but had - in her view - overemphasized the health problems associated with women's reproductive role and understated the full range of women's contribution to society. Women played an important role in primary health care, but men and women were responsible for achieving health for all.

Her delegation was pleased with the report but wished to suggest some additional subjects which it could have addressed. In paragraph 28, it covered some health hazards for pregnant women but neglected to mention many others, as the Australian and other delegations had pointed out. Such hazards included the impact of technology, changing working conditions and other factors which placed increased demands on women. As women assumed greater roles in decision-making, responsibility for health care must be assumed jointly by the two sexes.

Paragraph 113 of the report referred to mental health, but her delegation would have preferred more emphasis to be placed on the needs of mothers isolated at home with children. Because work forces were becoming increasingly mobile, many women lacked family and community support structures.

The problem of family violence was missing from the list of strategies in paragraphs 105-113. Health, police and other workers must be made aware of the existence of family violence and be prepared to deal with it.
The amended draft resolution on women, health and development read out at the beginning of the seventh meeting could be further improved by the revision of "women's health" to "women's physical and mental health" wherever it appeared and by the addition of a preambular paragraph after the ninth, to read "Concerned with the increasing incidence and impact of family violence on women and children". She hoped the sponsors of the amendments would endorse her suggestions.

Dr TSHABALALA (Swaziland) thanked the Director-General for his report. Most poor women - who were exposed, additionally, to poor health situations - lived in developing countries. Often they were heads of household due to the departure of men to seek employment in urban areas or abroad. Women faced the stresses of childbirth, care of extended families, disease control and enormous household and agricultural responsibilities.

In Swaziland, women had taken part in such community development activities as the construction of schools, the establishment and maintenance of water supplies, the promotion of literacy programmes, accident prevention and the creation of mother and child health and family planning services, but their own health was still generally poor and the maternal mortality rate was high, partly because health services were poorly coordinated and of restricted coverage. Women's health problems were also often aggravated by natural disasters which resulted in reduced agricultural production and malnutrition or by the loss of employment opportunities, which was a common phenomenon in many developing countries.

Her delegation, which supported the amended draft resolution read out at the beginning of the seventh meeting, would request the Director-General to provide technical support to Member States for developing integrated programmes with defined objectives, inputs and outputs, to be carried out following a review of existing activities and in collaboration with other United Nations agencies and nongovernmental organizations. The Director-General should also strengthen the regional offices in order to support integrated programmes on women, health and development and encourage Member States to develop policies to benefit women and children in conformity with the country's traditional values and culture and in a spirit of self-reliance.

Dr SEBINA (Botswana) observed that the Director-General's report called attention to some of the constraints faced by countries in persuading women to participate in the development process and, in that connection, chapter 4 stressed that efforts should be concentrated at the national level.

Currently women were at a disadvantage where participation in the development process was concerned. There was a need for an integrated national strategy for the fulfilment of women, and that in turn called for changes in attitudes, cultures and orientation. That was not an easy task and time was needed. Moreover, the situation was developing within the framework of a dynamic environment which itself was producing constant change. Legislation alone was not enough. In Botswana, for example, when the Government had decided to implement a programme of self-sufficiency in food, comprising projects with majority participation of women in a rural area, it had proved impossible to proceed with the programme because women did not have the necessary managerial skills. Their participation in science and technology would suffer unless action was taken to educate them appropriately.

In Botswana, women spent most of their time drawing water or producing food; if the time spent on domestic activities could be reduced, they would be enabled to participate in other areas. But women themselves were not entirely agreed as to the extent to which they should become involved in changing their role in a dynamically evolving environment, and a pragmatic approach was necessary, the aim being to incorporate them all in a process of meaningful participation.

His delegation endorsed the proposals contained in chapter 4 of the report and wished to become a co-sponsor of the draft resolution as amended.

Dr QUIJANO (Mexico) said that while Mexico had been traditionally male-oriented in terms both of government and ideology, governmental action during the previous 30 years, aided by the efforts of women themselves, had produced substantial change. Equality of the sexes was enshrined in the Constitution and implemented through legislation; women had the vote and enjoyed the same working conditions, including wages, as men. They had attained high office in government; several states had women governors and women were well represented in the Ministry of Education and the judiciary. Their advancement had also been aided by nongovernmental organizations.

The Ministry of Health was currently implementing an active programme to enhance the role of women in development and health. The programme was directed by women, who had read the Director-General's report with interest and had requested that their comments be transmitted to the Committee.
With reference to paragraphs 42-47 of the report, it was their view that while women everywhere had always contributed to development in a wide variety of ways, the benefits which they themselves had derived from development had always been marginal. Furthermore, the information contained in paragraphs 83-86 was inadequate as it referred exclusively to the participation of women as health care providers in activities such as conferences. The active contribution of women as providers of health care was a mainspring of the "Women, health and development" programme which PAHO was sponsoring through focal action points in the entire Latin American region.

Finally, in chapter 4, concerning forward-looking strategies, account should be taken of the fact that the life expectancy of women everywhere, including the Third World, was increasing; the case of older women should be borne in mind in developing activities for the promotion of women's physical, mental and social health.

Mr. CHAUHAN (India) welcomed the Director-General's report. His delegation supported the amended draft resolution in its latest form.

The Indian delegation believed that the health of a society to a large extent reflected the status enjoyed by its women. In fact, the health-for-all strategy acknowledged the position of women and gave pride of place to maternal and child health care programmes.

A number of programmes for improving the health status of women had been initiated in India. Maternal and child health care represented a major element in the national family welfare programme. Care had been taken to ensure the maximum involvement of women themselves in running those programmes in both the governmental and voluntary sectors. There was gradual progress towards a situation where more and more women would hold responsible positions in all fields of activity, and in that of health in particular.

The Constitution stipulated equality between men and women. The Equal Remuneration Act of 1976 provided for the payment of equal wages to both women and men for the same work. The Maternity Benefits Act of 1961 provided for 12 weeks maternity leave with full pay for women employees. The Factories Act decreed that crèches should be maintained for children below six years of age in every factory employing more than 30 women. The Medical Termination of Pregnancy Act enabled women to seek termination of pregnancies for medical, social, economic or psychological reasons without the consent of the husband. The Family Courts Act set up family courts to decide cases relating to matrimonial problems including the guardianship of children and adoption. The Child Marriage Restraint Act fixed the minimum age of marriage for females at 18. Particular attention had been paid to the problems of women in India during the United Nations Decade for Women. Efforts had been made to reassess the role of women in society, to evolve suitable strategies for promoting policies and programmes for women's welfare and those who had become an integral part of the planning process; indeed a chapter on "Women and development" had been included in India's sixth Five-Year Plan.

Programmes to promote the health of women had been intensified. The infrastructure for the delivery of maternal and child health services had been expanded substantially both in rural and urban areas to provide antenatal and postnatal care, skilled delivery, immunization and other prophylactic services. In view of the importance of female literacy in improving the status of women, various programmes and schemes had been launched to provide education for women. Education up to high-school level was free for girls. Gainful employment of women had been identified as a major entry point in promoting the integration of women into the development process. In that connection, the Government had taken a number of steps to increase employment opportunities for women through the provision of training in various industries and for the enhancement of their productive skills. Vocational training programmes for women through a network of industrial training institutes had been initiated.

Age-old inhibitions and prejudices continued to exist in society, however, and must be overcome in order to ensure proper enforcement of existing legislation and adequate utilization of the infrastructure which had been created for promoting the development of women. Generally speaking Indian women were not adequately equipped psychologically and financially to take advantage of the various social, legal and financial measures taken on their behalf. There was increasing awareness of the extent of the psychological and social problems involved but it was still necessary to accelerate substantially the process of awareness in order to narrow the gap between the spirit of various legislative measures for promoting the interests of women and their implementation.

The strategies proposed in the Director-General's report for improving the health status of women were relevant to the situation currently prevailing in a number of countries, including India, and should serve as important guiding principles for practical action by Member governments. The World Health Assembly should give its full support to their implementation.
Dr REILLY (Papua New Guinea) said that his delegation recognized the great importance of the interrelationship of women, health and development and welcomed the Director-General’s report.

The equal rights of women and men were guaranteed under the Constitution of Papua New Guinea. The attitude of women to health determined the health of the family and of the community, as it was they who determined the cleanliness of the house and the children and the type of water and food provided as well as ensuring family stability and mental wellbeing. Stress was laid on the importance of women in primary health care, and regional seminars had been held to promote the concept among various groups and organizations. The results of those seminars were also being used to educate the country’s male politicians.

His delegation strongly supported the draft resolution. It also supported the amendments of the Netherlands and Canada, as there was great concern at the incidence of family violence, and endorsed the appeal of the delegate of Mexico regarding the need to make proper provision for elderly women in health programmes.

Mrs POOLE (United Kingdom of Great Britain and Northern Ireland) remarked that the report discussed a number of areas of concern to women, and expressed the hope that the Director-General would give urgent consideration to implementing its recommendations. Her delegation supported the draft resolution. It also endorsed the comments of the delegate of Canada on the issue of family violence and mental health.

In the United Kingdom, the Sex Discrimination Act of 1975 made such discrimination unlawful in employment, training and related matters, in education, in the provision of goods, facilities and services and in the disposal and management of premises. An Equal Opportunities Commission had been established with statutory duties to work towards the elimination of discrimination and to promote equality of opportunity. In the United Kingdom women could assume the highest posts in the country; the monarch was the Queen and the Prime Minister was a woman.

In paragraph 41 of the report before the Committee, it was pointed out that in most countries, although the labour force in the formal health system tended to be predominantly female, women tended to fill the lowest paid, less prestigious jobs rather than those with status and decision-making power. The quality of their participation was limited owing to lesser access to training, information, education and opportunities. In the United Kingdom the Health Service was the largest employer of women; over 60% of the health revenue budget was spent on the nursing services and 90% of the nursing workforce was female. Those figures might well be repeated in other countries.

Addressing the Executive Board, the Director-General had commended the role played by, and the importance of, the nursing service in meeting the objectives of the World Health Organization and had stressed the urgency of ensuring that their education fitted them not only for their clinical responsibilities but for their educational and managerial roles. That statement had been welcomed by nurses throughout the world, and the United Kingdom delegation was confident that the profession would rise to the challenge and the opportunities. It must never be forgotten that, however high the diagnostic and clinical excellence of doctors might be, it was the skills of the nurses and other health workers in their preventive and rehabilitatory roles and in their support to the family that provided the maximum potential for the individual patient’s recovery. The draft resolution before the Committee referred to the importance of women as decision-makers in health; in that connection her delegation looked forward to hearing of future progress in increasing the role of women, including nurses, as health policy makers and managers.

Her delegation was pleased that the Director-General would be participating in the forthcoming World Conference on the United Nations Decade for Women, and hoped that his report would be discussed there and throughout the world so that its recommendations could become reality as the deadline for health for all by the year 2000 drew nearer.

Dr BATCHVAROVA (Bulgaria) commended the Director-General on his report. Solutions to the problems of women in society, their health and education, their participation in health care, and their social and economic development varied in different parts of the world. Maternal and child health was rightly given a central place in WHO’s concerns. However, the increasing involvement of women in various sectors of employment gave rise to other issues related to the impact of the workplace and of working conditions on the health and reproductive functions of women. In Bulgaria the social and legal equality of women was enshrined in the Constitution drawn up forty years earlier. Comprehensive legislation had been adopted for the protection of women, especially mothers. Social practice had in addition provided women with the conditions for full and equal development, so that they now worked shoulder to shoulder with men in all sectors of the social and economic life of the country, including health care. Measures had been taken to enable women to develop
themselves fully, whether physically, mentally or socially, and to combine social, political and home life in the best possible way. In Bulgaria each insured woman received paid leave until her child was two years old, after which she was entitled to leave without pay for a further year. During that three-year period the woman was considered as employed. Since 1975 all pregnant women engaged in employment where substances harmful to health were present, or where they were involved in heavy physical work, were moved from such employment seven days after pregnancy was diagnosed and transferred to lighter work with the same pay. Following the introduction of medical and social measures to protect the health of pregnant women and those who had recently given birth, infant mortality had sharply decreased. In the space of forty years the figure had dropped twenty-fold from 4% to less than 0.2%. During the United Nations Decade for Women, social organizations in Bulgaria were assessing their activities in the context of the problem of working women and had prepared new regulations concerning qualifications, employment protection, the improvement of working conditions, social security, rest centres, the organization of leisure time, and so on. Steps had been taken to protect the health and reproductive capacity of women medical health care workers. In collaboration with the Ministry of Health the medical workers' trade union had analysed morbidity rates, taking into account the number of days lost through illness and the number of cases of disablement, and had taken steps to reduce their incidence.

Despite the undoubted success achieved, she did not consider that all problems connected with women had been solved once and for all. Further problems affecting women would undoubtedly arise as the social and economic life of the country progressed; the necessary legislation and organization already existed to ensure that such problems might be solved as they occurred. Her delegation supported the draft resolution with the amendment proposed by the Netherlands delegation.

Mrs MEDA (Burkina Faso) said that a large proportion of her country's agricultural workers were women, who played an important role in the processing and marketing of food products. That situation was connected with the high rate of illiteracy among women, 98% of what amounted to some 55% of the total population. However, there was hope because since the People's Democratic Revolution of 4 August 1983 the women of Burkina Faso had organized themselves for the achievement of their total freedom. In that context she referred to the existence of the Ministry of Family Development; a women's mobilization section formed as part of the national secretariat established by the Committee for the Defence of the Revolution. That section supervised all the other women's organizations and directed social, political and cultural activities in favour of women. In the health sector, women participated effectively in maternal and child health centres which promoted health for all, and in the policy of immunization against communicable diseases through the multiplication of vaccination campaigns. The problems of frequent and too closely spaced pregnancies, abortion, and especially malnutrition and other deficiencies were being tackled by a plan of action drawn up by the Ministry of Family Development and the Ministry of Public Health, the main objectives of which were first to revise the unsuitable legislation in force forbidding the sale of contraceptives and publicity concerning their use, and secondly to bring about an understanding by the entire people of the interaction between population and development and the role of family planning in the fight against maternal and child mortality. The women of Burkina Faso were increasingly aware of their role; she referred in particular to the special effort to train supervisors and group leaders during the United Nations Decade for Women, and other projects such as equal access of women to development and the training of village midwives and supervisors. Some of those projects were supported by WHO and UNFPA; her delegation was grateful for that help and appealed to WHO to continue its aid to her country in its efforts to achieve the goal of health for all by the year 2000. Her delegation supported the draft resolution and wished to be added to the list of co-sponsors.

Professor CEVIK (Turkey) welcomed the draft resolution. As everyone would agree, the woman was at the centre of the family which, according to the Turkish Constitution, was the basis of the community. A strong and physically and mentally healthy nation could only exist where there was a healthy family. However, in the majority of countries women were regarded as second-class citizens of whom sacrifices were demanded but who received only minor rewards. Women, of whom a third were in employment outside the home, accounted for almost half of the Turkish population. Their living and health conditions had not greatly improved and, although they enjoyed civil rights as well as the right to vote, their literacy rate was still about 60%. However, in recent years an impressively high number of female students had enrolled in higher education establishments and there was a very high number of female academic staff in the 27 Turkish universities.

Some 12 500 health centres in cities and rural areas included maternal and child health care centres providing information and advising women on the realities of a health policy, on the right to their own health as well as that of their families. Primary health care was the
Professor DOUKI (Tunisia) welcomed the Director-General's report. The movement for the emancipation of women in Tunisia had begun nearly 30 years before. The promulgation of the civil status code following independence had established women's full citizenship and legal equality with men. In addition, polygamy had been abolished and divorce regularized, and other steps taken to enable women to enjoy their rights and participate in the country's development - including the establishment of girls' schools and the education and employment of women. The creation two years ago of a Ministry for Women's Development, headed by a woman, was an example of the progress made by women in Tunisia and her country's intention to work for the increased participation of women in development. Her delegation supported the amended draft resolution.

Dr JADAMBA (Mongolia) after commending the Director-General on his excellent report, said that within a comparatively short space of time Mongolian women, who before the People's Revolution of 1921 had played no role in political and economic life, had become an extremely important and reliable labour and intellectual resource of the socialist society of the Mongolian People's Republic, the Government of which had always set great store by the sociopolitical status of women and had taken steps to improve their working conditions and health. There was no illiterate woman to be found in Mongolia under the age of 70, and no women were excluded from the duty of building their own society, thereby making their lives more purposeful, prosperous and happy. There was no position in government and nongovernmental organizations where a woman could not be appointed as a leader. One-fourth of the deputies in the parliament were women. Women formed 46.6% and 57.2% of workers in material and nonmaterial production respectively. His delegation was convinced that the political and socioeconomic status of women could only be made equal to that of men by the elimination of illiteracy and through practical measures to foster their enthusiasm and initiative. What women needed most was the confidence and support which encouraged them and made them feel equal with men. In order to assume responsibility for taking care of the health of others, women should themselves enjoy and understand the meaning of health and know how it could be achieved. Unless they were convinced of the value they had for a country's development they would not feel equal with men. The Mongolian delegation supported the amended draft resolution.

Dr RUESTA DE FURTER (Venezuela) also welcomed the Director-General's report. The most recent reform of the civil code in Venezuela had granted civil equality for women and given both legitimate and illegitimate children the same rights. Her delegation wished to be included in the list of co-sponsors of the draft resolution.

Mr JENNANE (Morocco) thanked the Director-General for his excellent report. The draft resolution expressed a number of concerns regarding the high rate of maternal mortality, the adverse effects on women's health through inadequate working conditions and the frequency of nutritional anaemia: he felt that another should be included, namely the link between a woman's health and the number of pregnancies, especially when they were closely spaced. Some women in developing countries gave birth to ten or more children, closely spaced, with sometimes less than a year between births. Perhaps the co-authors of the text had not thought of that problem, but it might be appropriate to insert the following paragraph between the last two preambular paragraphs:

Concerned at closely spaced pregnancies, in particular in the developing countries, and the advantage of spacing out pregnancies as part of an appropriate family planning policy, integrated with the general programme for economic and social development of every country;

Dr TOURE (National WHO Programme Coordinator, Senegal) fully endorsed the Director-General's report. Development could not be achieved without the conscious and forceful participation of women, nor could the social target of health for all by the year 2000 be achieved without their cooperation.
Attention in Senegal was being concentrated on women and children, the two most vulnerable groups of the population, but those with the greatest potential. Encouraging results had been achieved as a result of the United Nations Decade for Women, although much still remained to be done with regard to education, training, health, nutrition, employment and remunerative activities, and in the legislative field. In the context of participation by women in development, there were 901 women's groups at present engaged in various agricultural and small industrial projects in Senegal. Those activities were financed and managed by the groups themselves on a basis of self-reliance. The groups also provided financial backing for rural maternity units, health posts and schools and were involved in health activities through the health committees, some of them headed by women.

The Senegalese villages of Diender and Ndomor were involved in the WHO project for women and health development in Africa; that project had been evaluated, and the villages visited by a number of international institutions and nongovernmental organizations. The women's group deserved support. Its activities were at present hampered by a water shortage resulting from long-standing drought and it had recently launched an international appeal for funds to help finance the drilling of a well. It was also making considerable efforts to find money in the community, and he asked the international community to respond to its appeal.

Senegal took a considerable interest in participation by women in development, and therefore supported the draft resolution and its amendments and wished to be included among its co-sponsors.

Mr HOSSAIN (Bangladesh) commended the Director-General's useful, informative and compact report, which reviewed the world situation and outlined some of the problems and strategies for the future.

In developing countries, with their relatively poor health conditions, women and children tended to suffer more than men. Those countries faced a difficult task in distributing scarce resources among competing demands, and ran the risk of spreading such resources too thinly to have any visible impact on any one sector. To make the best use of resources, therefore, a calculated policy and well-designed programmes were even more essential for developing than developed countries and could do much to prevent such threats to the health of women as maternal mortality and malnutrition, including anaemia. Legislative measures, too, could help in ensuring women social rights and the pursuit of a profession.

In Bangladesh there was a clear gap between the social and economic status of men and women. Traditionally, women had remained outside the mainstream of development, and social taboos, illiteracy, lack of training and consequent unemployment had forced them into a state of dependency. Of the 26 million labour force, only an estimated 6 million were women. However, development problems in a traditional society such as existed in Bangladesh were so diverse, complex and pervasive that to ensure the balanced socioeconomic development of all sectors, including health, full participation by women was an absolute necessity; it would at the same time better their social status and make them more knowledgeable about health and health-related matters. His country's second five-year plan, ending in June 1985, envisaged a more positive role for women in areas such as health and education and recognized their right to equal opportunity in productive activities. Its four main thrusts in women's affairs were to create a social atmosphere that would make women's participation in development activities increasingly possible, expand educational opportunities and specialized training in order to enhance their role in society as agents of change, expand credit and training facilities to foster increased participation by women in income-generating activities, and provide better protection and care of children. In pursuit of those objectives, his Government had adopted a multisectoral approach involving population, health, education and employment activities and had also provided that all training for productive activities would include a non-formal educational component embracing literacy, health, nutrition, family planning, agricultural extension and self-reliance. The administrative decentralization initiated by the Government in 1982, and due to be completed toward the end of May 1985, was also expected to provide greater impetus to the programmes for women's welfare. Since health and family planning were interrelated, they had been integrated in practice at local level by the posting of personnel to provide such services as a package. Again, the Government's extremely successful essential drugs policy, adopted in 1982, had made essential drugs accessible cheaply to the general public and was expected to have beneficial effects on the rural population, especially women and children.

The third five-year plan, due to begin in July 1985, gave priority to population planning, increased supply of basic needs for improvement of the nutritional level of the population, and primary health care. It also made provision for special services for mothers and children at local health complexes and health and family welfare centres. The principal
need at present was to mobilize adequate resources - both external and internal - to carry out those programmes effectively. The need to give adequate priority to women had been accepted by his Government. Under the Constitution, 30% of seats in Parliament were reserved for women in addition to the general seats for which women could stand in competition with men, and 20% of jobs in all services were also reserved for women. There was a separate Ministry for Women's Affairs headed by a woman Minister.

In conclusion, his delegation supported the draft resolution with the amendments proposed by France, Morocco and the Netherlands and wished to be included among its co-sponsors.

Mr CHANSI (Zambia) said that Zambia was one of the developing countries that recognized the important role that women played in society. Its President had on many occasions defended the involvement of women in the building of the nation. Zambia's Constitution guaranteed equal rights for all its citizens, and since independence a number of Zambian women had distinguished themselves in various responsible jobs.

Ten years after independence, his Government had recognized women and children as the population group most exposed to preventable diseases. With that in mind the 1974 manifesto of the United National Independence Party had accorded the highest priority to prevention, with emphasis on the welfare of women and children through the strengthening of community hygiene by means of health education and the provision of basic sanitary facilities, protective measures such as immunization, national research activities in nutrition with a view to promoting easily available food products, and family planning activities directed towards the maintenance and improvement of the quality of health of mothers and children. Emphasis was also being placed on those activities in primary health care.

Zambian women, including those in rural areas, were no longer confined to the home. In urban areas, for example, more women were in formal employment and could contribute to meeting their family needs. Others were engaged in private enterprise such as buying and selling food and vegetables in rural areas. Most women were involved in agricultural activities and a number of them had joined cooperatives as a result of encouragement by the Government.

The project for the participation of women in health development in Zambia was progressing well. It had clearly shown that women, even if relatively uneducated, were quite capable, given the opportunity, of making their own decisions on health matters in their society and of looking after their own health needs with the help of community workers. In addition, they engaged in small-scale industrial activities and had independently made group ventures into agriculture. Women played a significant role in Zambia in making other women aware of their health needs and encouraging them to use the health facilities provided.

Women also played a large part in encouraging other women to be self-reliant and, without waiting for action from their menfolk, to organize themselves collectively or individually to generate funds to supplement their husbands' income. Through the influence of the Women's League, the Government had set up a department in the Ministry of Finance and National Commission for Development to coordinate all women's activities and to mobilize and distribute the funds required for the various projects. Zambian women viewed the Decade for Women as a planning period. It had enabled them to take a critical look at their health, socioeconomic and political status. His country therefore believed that, with support from the Health Assembly, much would be achieved, and it supported the draft resolution as amended.

Mr MBALOULA (Congo), commending the Director-General's excellent report, said that women in the Congo received the same educational opportunities as men and enjoyed the same rights. For over 20 years Congolese women had been aware of the role incumbent on them. The Revolutionary Union of Women of the Congo had, when celebrating its twentieth anniversary in 1985, recalled a number of its successful actions, including the adoption by the People's National Assembly of the Family Code, the making of family planning methods available throughout the country, and the participation by women in all major political decisions with an impact on social and economic development. Women were represented at all levels of Government, local and national, and were also fully involved in health matters. At the last graduation ceremony in Brazzaville, one-third of all graduates in medicine had been women.

Through the initiative of the local section of the Revolutionary Union of Women of the Congo, and with technical and financial assistance from the WHO Regional Office, his country had launched a sala ngolo (self-help) project at the village of Naabouana, in which women had taken over complete responsibility for health and development. The project had already proved its merits, since another of the same kind had been started in the north of the country and further extensions were expected. However, much still remained to be done for Congolese women, who had a special need for support and encouragement, as the Government was well aware. For some time past seminars had been held at national and local level on the
storage of rural produce and its dispatch for marketing in the towns, and for the education and information of women on nutrition, immunization and the prevention of local endemic diseases. There was also a need to lighten the burden of women in rural areas by improving working conditions and ensuring greater access to medical care during pregnancy and childbirth.

The Congolese delegation welcomed the continuing attention WHO was giving to women's problems and fully supported the draft resolution with its amendments.

Mr MOHAMMAD (Nigeria) congratulated the Director-General on his report. The Nigerian delegation wished to be associated with the sentiments and proposals therein.

There was no doubt that women had taken their proper role in Nigeria. All the 19 state governments had been mandated at the start of the present administration to include at least one woman commissioner in their cabinets. Of the 30 or so permanent secretaries in the Federal Civil Service, three or four were women. Women were represented in all sectors of the economy. With regard to the health sector, about 10 of the 19 state commissioners of health were women. Many of the doctors, nurses and other health workers, particularly maternal and child health care and family planning staff, in the Nigerian ministries of health, teaching and general hospitals and health centres and clinics were women. Women were thus playing a dominant role in the health sector.

He urged the Committee to approve the draft resolution, with all its amendments, unanimously.

Mr PALSØN (Iceland) commended the Director-General's excellent report, which had been the subject of very thorough review by the Committee. He associated himself with the many points of substance made during the debate and, in particular, the remarks made by the delegate of Norway. He was prepared to accept the draft resolution with the amendments proposed by the Netherlands; however, since other amendments had also been put forward, it might be useful to set up a drafting group to produce a final version of the draft resolution before putting it to the Committee for approval.

Dr KESSLER (World Federation of Public Health Associations) speaking at the invitation of the CHAIRMAN, said that the World Federation was a union of nongovernmental, interdisciplinary professional associations working for public health. It shared the Committee's enthusiasm in considering the issue before it and welcomed the Director-General's report.

The twentieth century was likely to be remembered for two major achievements in human development: a health revolution for mankind and the emergence of fully emancipated women as full participants in all areas of human progress. Health workers and WHO had a significant role to play in those interconnected developments. As the report pointed out, perhaps the major obstacle was continued resistance to any change in oppressive and discriminating social attitudes. In addition, a majority of people were still uninformed on the subject and uncommitted to the advancement of women.

The Federation had recently established a centre for women and health, which sought to exert influence by promoting the transfer of technology, mobilizing human resources and advocating action in which the link between women's development and health was recognized. The centre would help to promote understanding of the special health and nutrition needs of women and how to meet those needs, of constraints to women's access to health services, and of the importance of women's work both within and outside the home.

Progress in primary health care obviously depended on further involvement and consideration of women. It could promote or constrain women's development depending on whether or not it was appropriate. Mothers should be placed at the centre of child and family care, and they must be enabled to provide a significant degree of primary health care if health for all was to be achieved. Unless women were given the necessary support, primary health care could add to their already heavy burdens and further compromise their development. The Federation had become aware of the degree of ignorance prevailing, the lack of good information available, and the difficulty of access to the little information there was. The centre would therefore endeavour to develop appropriate data bases, collect documentation and training material, make resource inventories, carry out research, disseminate material, and heighten awareness of the need to make primary health care more relevant to the roles of women. The Federation welcomed WHO's intention to function as a clearing-house and to promote further research on primary health care and women. It was expected that the Federation's centre would collaborate closely in that work.

The report on the Technical Discussions at the current Health Assembly had urged that the partnership between governments and nongovernmental organizations be intensified, with WHO playing a dynamic role in facilitating such intensification. The area of women's health and development could be particularly fruitful in stimulating that partnership.
The Federation enthusiastically endorsed the draft resolution before the Committee, together with the amendments proposed. Technical Discussions at a future Health Assembly on women in health and development might provide an opportunity to explore the subject further and to give broader consideration to women's economic, social and reproductive roles in the pursuit of health for all. That would be a logical continuation of the Technical Discussions at the Thirty-eighth and Thirty-ninth World Health Assemblies on collaboration with nongovernmental organizations and on intersectoral cooperation for health for all.

Dr DE CARVALHO (Cape Verde) observed that her Government attached great importance to equality between the sexes and the topic of women, health and development, since women represented more than half the population of her country and played a fundamental role in its development, participating actively in all spheres of life, particularly health, education, fisheries, agriculture, politics and family life. Her Government greatly appreciated and strongly endorsed the Director-General's report.

Dr PETROS-BARVAZIAN (Director, Division of Family Health and Focal Point, Women, Health and Development) said that the encouraging comments of delegates on the complex and wide-ranging issues under discussion would be most valuable in the Organization's future efforts to support Member States in their plans and activities on women in health and development and as part of their strategies for health for all.

The Secretariat looked forward to collaborating with all interested parties, including nongovernmental organizations and other organizations of the United Nations system, with a view to supporting national efforts at the country level.

The CHAIRMAN observed that overwhelming support had been expressed for the draft resolution under consideration, with the amendments submitted by the delegations of Canada, France, Morocco and the Netherlands. He suggested that a revised text incorporating all the amendments be circulated for consideration at the next meeting.

It was so agreed (see summary record of the ninth meeting, section 1).

Health assistance to refugees and displaced persons in Cyprus: Item 33.3 of the Agenda (Resolution WHA37.24; Document A38/13)

Dr GEZAIRY (Regional Director for the Eastern Mediterranean), introducing the item, recalled that, in resolution WHA37.24, the Thirty-seventh World Health Assembly had requested the Director-General to continue and intensify health assistance to refugees and displaced persons in Cyprus, in addition to any assistance made available within the framework of the efforts of the Coordinator of United Nations Humanitarian Assistance in Cyprus, and to report to the present Health Assembly on such assistance.

The report before the Committee (document A38/13) outlined the joint UNHCR/WHO action taken so far to meet the health and medical needs of refugees and displaced persons in Cyprus during the biennium 1984-1985. An international team had visited the country on 10 July 1984 to advise on the expanded programme of immunization and primary health care. Some US$ 200,000 was being provided in 1984-1985 for the Nicosia regional training centre for maintenance and repair of medical equipment. WHO had awarded 16 fellowships for training in the maintenance and repair of medical equipment, surgical instrument supply, orthopaedic surgery, quality control of drugs, pharmaceutical inspection, psychotherapy, chronic respiratory diseases control and human cytology. The Larnaca General Hospital, built with technical advice from WHO and funds from UNHCR, had been opened in March 1985.

WHO was contributing a total of US$ 568,000 from its regular budget during the biennium 1984-1985 for various health projects. In addition to funds from the regional regular budget, WHO collaborative programmes in Cyprus were receiving UNHCR support for the health of refugees, and funds from the World Bank and the Kuwait Fund for International Development.

The CHAIRMAN drew attention to a draft resolution sponsored by the delegations of Algeria, Australia, Cuba, France, Ghana, Greece, Guyana, India, Mali, Malta, Mexico, Tonga, United Republic of Tanzania, Yugoslavia and Zambia, which read as follows:

The Thirty-eighth 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, WHA32.22, WHA34.20, WHA35.18, WHA36.22 and WHA37.24;
Noting all relevant United Nations General Assembly and Security Council resolutions on Cyprus;
Considering that the continuing health problems of the refugees and displaced persons in Cyprus call for further assistance;

1. NOTES with satisfaction the information provided by the Director-General on health assistance to refugees and displaced persons in Cyprus;

2. EXPRESSES its appreciation for all the efforts of the Coordinator of United Nations Humanitarian Assistance in Cyprus to obtain the funds necessary for the Organization's action to meet the health needs of the population of Cyprus;

3. REQUESTS the Director-General to continue and intensify health assistance to refugees and displaced persons in Cyprus, in addition to any assistance made available within the framework of the efforts of the Coordinator of United Nations Humanitarian Assistance in Cyprus, and to report to the Thirty-ninth World Health Assembly on such assistance.

Mr FALZON (Malta), introducing the draft resolution, said that his delegation had studied the Director-General's report (document A38/13) concerning the continuation of the health assistance provided to Cyprus by UNHCR 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 for the achievement of the various health projects in Cyprus as outlined in the Director-General's report. It had also noted with satisfaction the increase in the contribution from the WHO regular budget for the biennium 1984-1985 for the various health projects in Cyprus.

While expressing appreciation for the efforts of the various bodies concerned to obtain the necessary funds for those activities, the sponsors had submitted the draft resolution in which the Director-General was requested to continue and intensify health assistance to refugees and displaced persons in Cyprus. The sponsors earnestly believed that the draft resolution would meet with the Committee's unanimous approval.

Mrs NASCIMBENE DE DUMONT (Argentina), Mrs WOLF (German Democratic Republic) and Mr SAMARASINGHE (Sri Lanka) said that their delegations wished to be co-sponsors of the draft resolution.

Professor SHIRE (Somalia) expressed full support for the draft resolution.

The draft resolution was approved.¹

Mr TARLAN (Turkey) said that his Government's policy on the Cyprus question was well known. He had no intention of raising issues extraneous to the agenda, but he wished to emphasize certain points with regard to the resolution.

First, 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. Secondly, there were no refugees, but only displaced persons from both of the communities in Cyprus.

On that understanding, his delegation had joined in the consensus on the draft resolution on humanitarian grounds.

Mr NICOLAIDES (Cyprus) observed that refugees and displaced persons still unfortunately existed in Cyprus and needed help with housing and food and also health assistance, which it was important for WHO to provide as long as necessary. The Director-General's report showed the broad measure of assistance provided and reflected the serious and continuing effort of the Government of the Republic of Cyprus to meet the needs and alleviate the sufferings of refugees and displaced persons on the island. He expressed the appreciation of the Government and people of Cyprus for the genuine and continued interest shown by the Health Assembly in the plight of the refugees and displaced persons concerned, and he hoped that their tragedy would soon be over. The Secretary-General of the United Nations was making every effort to bring nearer a just, viable and lasting solution to the problem of Cyprus - a solution that could contribute to peace and security in a sensitive area of the world. His Government was cooperating closely and with good will with the Secretary-General in that quest.

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA38.25.
He expressed his appreciation to the delegate of Malta for introducing the draft resolution just approved and to all the sponsors, who had shown continued interest in and support for the cause of the refugees and displaced persons in Cyprus. He was confident that the Director-General and his staff, particularly the Regional Director for the Eastern Mediterranean, would spare no effort in providing health assistance to refugees and displaced persons in Cyprus on the basis of the draft resolution just approved.

**Health and medical assistance to Lebanon:** Item 33.4 of the Agenda (Resolution WHA37.25; Document A38/14)

Dr GEZAIRY (Regional Director for the Eastern Mediterranean), introducing the item, recalled that the previous Health Assembly, in resolution WHA37.25, had requested 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 that purpose, as far as possible, funds from the regular budget and other financial resources. The Committee had before it a report on health and medical assistance to Lebanon in 1984 and the first quarter of 1985 (document A38/14). Assistance had been interrupted by new outbreaks of armed conflict which had led to a state of emergency. The plan for the reconstruction of the health services in Lebanon, proposed by the WHO/League of Red Cross Societies mission, had thus been left in abeyance.

The health working group lead by the WHO representative in Beirut had continued to coordinate relief operations with governmental and nongovernmental organizations providing assistance to displaced persons in Lebanon. The Organization had provided emergency assistance and had channelled pharmaceutical contributions from various donors. Other supplies and equipment provided in response to urgent requests had included intravenous fluids, tetanus globulins and toxoids, plasma expanders, disinfectants and medicaments to meet emergency needs.

For the biennium 1984-1985, WHO was providing a total of US$ 1,140,000 from its regular budget. One fellowship had been awarded for training in public health and a grant of US$ 30,000 had been made to the American University in Beirut in support of education programmes. WHO's presence had been maintained during the period and the Organization continued actively to support and coordinate medical and health-related assistance. Close collaboration was also maintained with other United Nations organizations, particularly UNICEF, UNRWA and the Office of the United Nations Disaster Relief Coordinator.

The CHAIRMAN drew attention to a draft resolution submitted by the delegations of Algeria, Bahrain, Djibouti, India, Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Qatar, Saudi Arabia, Somalia, Tunisia and United Arab Emirates, which read as follows:

The Thirty-eighth World Health Assembly,
Recalling resolutions WHA29.40, WHA30.27, WHA31.26, WHA32.19, WHA33.23, WHA34.21, WHA35.19, WHA36.23 and WHA37.25 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 1983-1984 and the first quarter of 1985;
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 1984-1985;
1. **EXPRESSIONS** its appreciation to the Director-General for his continuous efforts to mobilize health and medical assistance for Lebanon;
2. **EXPRESSIONS** 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-ninth World Health Assembly on the implementation of this resolution.

Mr BROCHARD (France), Mr HOSSAIN (Bangladesh) and Dr MOUCKA (Zaire) said that their delegations wished to be co-sponsors of the draft resolution.

Mr AL-DAHER (Saudi Arabia) said that, in view of the suffering in Lebanon following the destruction of recent years, and the assistance required for overcoming the obstacles to reconstruction of the health infrastructure in order to achieve the goal of health for all by the year 2000, his delegation hoped that the draft resolution before the Committee would be unanimously approved.

The draft resolution was approved.¹

The meeting rose at 17h30.

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA38.26.
NINTH MEETING
Thursday, 16 May 1985, at 9h00
Chairman: Mr R. ROCHON (Canada)

COLLABORATION WITHIN THE UNITED NATIONS SYSTEM: Item 33 of the Agenda (continued)

Women, health and development: Item 33.2 of the Agenda (continued from the eighth meeting, first part)

The CHAIRMAN drew attention to the following revised draft resolution consolidating the text recommended in resolution EB75.R15 as amended by the delegations of Finland, France, Norway, Sweden and Switzerland and presented at the seventh meeting, and the further amendments proposed by the delegations of Canada, France, Morocco and the Netherlands:

The Thirty-eighth World Health Assembly,
Taking note of the report of the Director-General and of the views of the Executive Board on the health situation of women and their role in health and development, and particularly in the implementation of the Global Strategy for Health for All by the Year 2000;
Noting the close relationship between equal rights for men and women and the participation of women in health activities and in the promotion of health for all, particularly as decision-makers;
Recalling previous resolutions of the Health Assembly on the role of women and, in particular, resolutions WHA28.40, WHA29.43 and WHA36.21;
Recognizing the great importance of the forthcoming World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace;
Concerned at the slow progress made by a number of countries in realizing the objectives of the United Nations Decade for Women, which are formulated in the reports of the World Conference of the International Women's Year, Mexico City (1975), the World Conference of the United Nations Decade for Women, Copenhagen (1980), and recalling the report of the International Conference on Population, Mexico City (1984), particularly with regard to women's physical and mental health and also with regard to their social security and the safeguarding of their rights;
Concerned at the very high maternal mortality rates in many countries and at the frequency and severity of the repercussions on women's physical and mental health of certain practices, particularly during pregnancy or childbirth but also during puberty or childhood;
Concerned at the adverse effects on women's physical and mental health and the risks for their children produced by inadequate conditions of domestic work or paid employment;
Concerned at the frequency of nutritional anaemia in many countries, especially among pregnant women;
Concerned at the close spacing of pregnancies, particularly in the developing countries, and at the importance of adequate spacing of pregnancies as part of an appropriate family planning policy integrated within the general economic and social development programme of each country;
Bearing in mind with anxiety the prevalence in some countries of adolescent marriages and pregnancies;
Concerned with the increasing incidence and impact of family violence on women and children;
Aware that in some countries the general public does not know enough about the nature of the risk to the health or even the life of women presented by such factors as deficient or inadequate diet, lack of hygiene, excessive workloads and pregnancy prior to full physical maturity and corresponding mental development, risks that may also have repercussions on the health of the children;
Recalling the correlation between the education of mothers and the reduction of child mortality levels;

1. THANKS the Director-General for his report;

2. CALLS UPON Member States to show greater concern, within the context of national activities and international cooperation, for the protection of women's physical and mental health, particularly as regards the nutrition of women, the health of pregnant women and young mothers and conditions of work; to assist women to carry out their functions as providers of primary health care; to strengthen their efforts to provide women with greater opportunities to pursue activities in the context of the realization of the objectives of the strategies for health for all; and to take an active part in the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women;

3. REQUESTS the Executive Board to monitor the development in the field of women, health and development;

4. REQUESTS the Director-General:

   (1) to ensure the Organization's active participation in the World Conference and to present to it a report on the role of women in health and development, on the principal risks threatening women and on the possibilities of guarding against those risks;

   (2) to continue to pay close attention to cooperation with, and to provide expertise to Member States in their activities to promote women's physical and mental health, including information and education of the public, to intensify the participation of women, particularly as decision-makers, in health and socioeconomic development, and to assist them to evaluate the effect of health development programmes and social services on the situation of women and on the protection and promotion of women's physical and mental health;

   (3) to strengthen coordination with the other United Nations agencies that pay special attention to the economic role of women;

   (4) to evaluate the contribution made by WHO's programmes to the promotion and protection of women's physical and mental health and the effects of these programmes on the participation of women in health activities;

   (5) to report periodically to the Executive Board and the Health Assembly on the progress achieved in this field.

The draft resolution was approved.¹

Liberation struggle in southern Africa - assistance to the front-line States, Lesotho and Swaziland: Item 33.5 of the Agenda (Resolution WHA37.28; Document A38/15)

Dr MONEKOSSO (Regional Director for Africa), introducing the item, explained that the report before the Committee, submitted in pursuance of resolution WHA37.28, contained a description of the measures taken during the biennium 1984-1985 to meet the public health needs of front-line States and the national liberation movements recognized by the Organization of African Unity (OAU). WHO headquarters and the Regional Office for Africa had continued to collaborate closely with the countries concerned, with the various agencies and organizations of the United Nations system, with OAU, with the International Committee of the Red Cross, and with other nongovernmental organizations. That cooperation had focused particularly on protecting the health of refugee communities. Where assistance to front-line States was concerned, WHO was collaborating closely with their national authorities and those of Lesotho and Swaziland in order to assist in improving the health conditions of the populations of those countries, as well as of the refugees coming from South Africa and Namibia. In addition WHO, through its Regional Office for Africa, the WHO liaison officer with OAU, the United Nations Economic Commission for Africa and the WHO programme coordinators in Angola, United Republic of Tanzania and Zambia, continued to maintain close contact with the national liberation movements recognized by OAU with a view to meeting their health needs.

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA38.27.
The CHAIRMAN drew attention to the following draft resolution sponsored by the delegations of Algeria, Botswana, Burkina Faso, Guinea-Bissau, Lesotho, Mozambique, Sudan, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe:

The Thirty-eighth 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;

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 capabilities, 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-ninth World Health Assembly on the progress made in the implementation of this resolution.

Mr CHANSHI (Zambia), introducing the draft resolution, said that thanks were due to the Director-General for his untiring efforts to help the front-line States. Zambia, as a sponsor of the draft resolution and as a front-line State itself, wished to make its position abundantly clear. The front-line States in southern Africa had not enjoyed any meaningful peace or security since the early 1960s, although the South African authorities had attempted to create a contrary impression. Angola, Mozambique and Zimbabwe were now independent, but the situation in the region remained unstable owing to South Africa's illegal occupation of Namibia in defiance of international opinion, to its policy of apartheid, which denied over 23 million black people their basic human rights, and to its efforts to destabilize the sovereign States of Mozambique, Lesotho, Angola, Botswana, Zimbabwe and, of course, Zambia.

Sensing danger and the speedy penetration of the liberation movements, the fascist Government of South Africa had now devoted its greatest military effort to Namibia and Angola, where it had made longer and deeper raids aimed at destroying the South-West Africa People's Organization (SWAPO) bases and at assisting certain forces opposed to SWAPO and to the Government of Angola. It had also adopted an increasingly aggressive policy towards neighbouring States which rendered moral, diplomatic, material and rear-base support to the liberation movements; in particular, it was providing material support for rebel bandit operations in Matebeleland in Zimbabwe and in the North-Western Province of Zambia, where large sums had had to be diverted from new projects to rebuild the many schools and rural health centres that had been damaged. Despite the "N'Komati Accord" South Africa continued
to support the Mozambique resistance movement, which had repeatedly sabotaged infrastructural facilities in Mozambique and in Zimbabwe. In the North-Western Province of Zambia the notorious Mushala gang had caused serious damage to property and life, attacking many trucks laden with essential drugs and other consumer goods. The situation was so critical that many people feared to visit the Province.

In view of the anticipated intensification of the liberation struggle, South Africa was likely to increase its destabilization activities in an attempt to deter neighbouring black States from giving support to the liberation movements. However, despite all the provocations, threats and intimidation, the front-line States had stressed their determination to provide the liberation movements with all necessary support until such a time as Namibia was genuinely independent and the system of apartheid in South Africa was completely dismantled.

The support given to liberation movements had been costly in terms of loss of life and damage to economic infrastructures in the front-line States, whose development had been retarded by the acts of sabotage undertaken by South Africa for the purpose of weakening their economies and thereby creating a ring of economically dependent client States. In order to counter South Africa's attempts to destabilize its neighbours, the independent States of southern Africa had formed the Southern African Development Coordination Conference (SADCC), whose main objective was to harmonize development plans among Member States and thereby reduce their dependence on South Africa. In addition, the southern African States, together with some East African States, had formed the Preferential Trade Area, which was designed to boost commercial and economic cooperation in the respective areas of Africa.

In view of all those considerations Zambia strongly urged the international community, particularly the developed countries, to render as much economic and material support as they could to individual front-line States or to SADCC, bearing in mind the immense suffering of the grief-stricken African victims of settler rule. Being intimately acquainted with the heart-rending facts, Zambia and the other front-line States had no wish whatsoever to have to turn back needy creatures of God who had been forced to flee from their countries as a result of circumstances beyond their control. His delegation therefore fully supported the draft resolution before the Committee and hoped that WHO would continue to take appropriate and timely action to provide assistance to the front-line States and to Lesotho and Swaziland.

Mr TOMO (Mozambique) after congratulating the Director-General on his report and on his efforts to implement resolution WHA37.28, said that in 1984 as in previous years the armed bandits recruited, trained and financed by South Africa had continued their destabilizing operations in the neighbouring countries, despite the peace initiatives undertaken by some countries. Over one year after the signature of the non-aggression agreement between the People's Republic of Mozambique and the Republic of South Africa peace had not yet been re-established. The Republic of South Africa continued to be the main element responsible for the war situation in Mozambique. Economic sabotage, robbery, massacres of old people, women and children, and the plunder and destruction of health units, schools and cooperatives by the armed bandits had had marked effects on the people's health. The support received from WHO, as well as the solidarity of friendly countries and organizations, had contributed to an improvement in the situation, although there were still all too many problems to be solved. Mozambique needed urgent financial support for the re-equipment of more than 311 health posts and centres that had been destroyed or damaged during the years 1982-1984 its main priorities in the reconstruction of the health infrastructure being the acquisition of equipment, essential drugs and ambulances. His delegation was extremely grateful to all those countries and organizations that were supporting Mozambique in the difficult situation in which it found itself and urged all members to support the draft resolution before the Committee.

Mr MOHAMMAD (Nigeria) said that his country's position with regard to apartheid and assistance to the front-line States was too well known to require further explanation. After congratulating the Director-General and the Regional Office for Africa on the efforts which they had made to assist the front-line States, he expressed the hope that the draft resolution would be approved unanimously. His delegation wished to be added to the list of sponsors.

Mr KWEN Seung Yeun (Democratic People's Republic of Korea) noted with approval that some progress had been made in the implementation of resolution WHA37.28 on assistance to the front-line States, Lesotho and Swaziland. Nevertheless, those countries were still suffering from the consequences of armed banditry and attempts at political and economic destabilization by the South African racists. In such circumstances WHO should provide them with continuous assistance for the improvement of their health facilities. His Government would continue to provide assistance in health and other related fields.
Mr CHAUHAN (India) said that his delegation fully supported the draft resolution before the Committee and wished to be added to the list of sponsors. The subject matter of the draft resolution had received the full support of the Ninth Meeting of the Health Ministers of Non-aligned and Other Developing Countries, and he was confident that the text would be approved unanimously. The activities of the racist regime of South Africa continued to threaten and disrupt peace and development. India had consistently called for the imposition of comprehensive and mandatory sanctions against South Africa as an essential step towards the eradication of the evil system of apartheid, which was an insult to mankind.

Mrs LUETTGEN DE LECHUGA (Cuba) said that her delegation was aware of the many important health problems facing the front-line States, Lesotho and Swaziland and appreciated the efforts which WHO was making to improve the health situation of the peoples of those States. Despite the numerous resolutions adopted by the United Nations General Assembly and the Security Council, the populations of Namibia and South Africa were still subjected to the inhuman policies of colonialism, racism and apartheid. The countries attacked by the South African regime were having great difficulties with their socioeconomic development, as well as with health. The health of the peoples of South Africa and Namibia could not be assured until those peoples obtained freedom and independence for their basic rights. In that connection the President of Cuba had recently made a statement in which he had stressed Cuba's close links with black African countries united by opposition to apartheid irrespective of their political regimes, its own resolve opposition to apartheid, and its support for all those fighting against it. Since the goal of health for all by the year 2000 was clearly unattainable as long as apartheid persisted, her delegation unreservedly supported the draft resolution before the Committee and wished to be added to the list of sponsors.

Mr Joung Yung SUN (Republic of Korea) said that his Government had consistently pursued a policy opposing all forms of racial discrimination, and had consequently supported and joined in the efforts and assistance measures taken by the various bodies in the United Nations system to benefit the front-line States and Namibia. It firmly supported WHO action aimed at protecting and promoting the fundamental rights of the people of those regions, and also supported the draft resolution before the Committee.

Miss TOUATI (Algeria) said that her delegation approved WHO's assistance to the front-line States, to Namibia and to the national liberation movements in southern Africa. Apartheid, rightly described as a crime against humanity, and unanimously condemned, still formed the cornerstone of the racist policy of the white minority, which used it to consolidate its domination of the people of South Africa and to maintain its control of Namibia. Efforts to keep the people of South Africa and Namibia in a state of subservience included a series of violations of human rights and fundamental freedoms. An entire arsenal was being built up to repress any revolt against the system, which was itself doomed. Such savage repression was reflected in daily acts of violence by the minority in power, and through ceaseless persecution, imprisonment and torture.

The large protest movements bore witness to the mobilization of the South African people and their determination to fight for their freedom. The international community, recognizing the legitimate nature of that fight, should strengthen its solidarity and support for the people of South Africa. The Algerian delegation was confident that WHO would continue to do everything in its power to improve the health situation of the people of southern Africa. It supported the front-line States and deplored the many forms of assistance still given to the Pretoria regime. The Organization was to be congratulated on its humanitarian activity vis-à-vis the national liberation movements recognized by the Organization of African Unity. Algeria welcomed the international collaboration and assistance given to those movements and was convinced that the health and welfare of the people of South Africa and Namibia would only be achieved when they gained their freedom and independence.

The international community should endeavour to isolate the South African regime both politically and economically, and should refuse any form of international cooperation that had harmful consequences for the victims of that regime. Some Western countries, which under other circumstances had promptly resorted to strict economic sanctions, doubtless recognized the deterrent nature of such measures, and it was difficult to understand their reluctance to apply them to South Africa.

Dr JADAMBA (Mongolia) said that his delegation supported the measures taken by the Organization to improve the health situation of the front-line States. Bearing in mind the situation of the people in those countries as a result of the destabilizing measures taken in
South Africa, and bearing in mind the material, financial and technical needs of the front-line States, the Mongolian delegation supported the draft resolution and wished to be added to the list of co-sponsors.

Dr HACEN (Mauritania) said that his delegation welcomed the efforts made by the Organization in support of the front-line States, Lesotho, Swaziland, Namibia and the national liberation movements in southern Africa, and thanked the Director-General for the assistance described in his report. Mauritania wished to be one of the co-sponsors of the draft resolution.

Mrs CHEN Haihua (China) thanked the Director-General for his efforts in assisting the front-line States. The South African authorities had for a long time stubbornly pursued their colonialist regime and had obstructed the independence of the Namibian people, prolonging their suffering and misery and severely hindering their social, economic, cultural, educational and health development. The liberation struggles of the people of South Africa and the national liberation movements had gained the support of people the world over and of the international organizations that promoted social justice.

The Chinese delegation appreciated the efforts of WHO to implement resolution WHA37.28 and supported the draft resolution. It was to be hoped that WHO would continue to make positive contributions to the liberation struggles in southern Africa and to the improvement of the health services, treatment and conditions of the people of that region.

Mrs AMATHILA (Namibia) said that Namibia was still under the illegal occupation of the South African apartheid regime, which refused to grant internationally recognized independence to it in accordance with United Nations Security Council resolution 435. Apartheid should be declared a health hazard and be known as such, and should not be allowed to continue to flourish. If health for all by the year 2000 was indeed a common goal, the people of Namibia and southern Africa could not hope to attain it in the 15 years which were left.

Two health systems existed in South Africa and Namibia, one for whites and another for blacks, and the difference in them was clear from a comparison of the infant mortality rates for Windhoek: for blacks, the rate was 165 per thousand live births as opposed to 21 per thousand live births for whites. In spite of that difference, South Africa's black population was frequently told by the whites how good its position was compared with that of the blacks in Africa's drought-stricken areas, for example; yet the only valid comparison was with South Africa's white population. Namibia was a potentially rich country, with a population of less than two million, and there was no reason why the infant mortality rate among the blacks should not be as low as that of the whites.

In the area of health manpower training, South Africa had only trained 23 Namibian doctors over a period of some 60 years, whereas the South-West Africa People's Organization (SWAPO), in the 25 years of its existence, had, with assistance from WHO and other sources, trained 15 doctors and had brought down the infant mortality rate to 40 per thousand live births.

Thanks and appreciation were due first and foremost to the front-line States, particularly Zambia, Angola and Botswana. Zambia had provided training facilities in its institutions, had treated SWAPO's sick, provided land for the setting-up of health services, had opened its doors to disabled Namibians, and had provided 90 places in its training institutes to war victims for vocational training and rehabilitation. It had also shared its meagre resources with SWAPO. Angola was doing its best in spite of the fact that the health facilities in occupied Angola had been completely destroyed by the racist regime. Over 60,000 Namibian refugees were being looked after there, despite the bombings and destruction, and were sharing the health services. Angola had also provided land for the establishment of health services. SWAPO was equally grateful for the assistance provided by countries far removed from southern Africa: many Member States of WHO from eastern and western Europe and from South America had provided assistance, and although the educational level of the Namibian people was low, training was possible on account of such assistance.

Colonialism and apartheid were two health hazards that had to be fought as such. The Namibian people thanked the Director-General and Member States for the assistance so far given, and were confident that that would be increased and improved in the future. The Namibian people had proved that they were serious about health care. As far as they were concerned there could be no going back, and they would continue their struggle until South Africa brought its illegal occupation to an end.

Mr SOKOLOV (Union of Soviet Socialist Republics) thanked the Director-General for his report on the assistance of WHO to the front-line States and to the national liberation
movements recognized by the Organization of African Unity. The Soviet delegation supported WHO activity in that area and believed it should continue in the future. Assistance to the liberation movements was possible not only within the framework of WHO's regular budget, but also on a bilateral basis. The Soviet delegation endorsed the statements condemning the racist regime of South Africa, whose actions gave rise to political and economic destabilization in the area, and which pursued a policy of apartheid and racial hatred. The Soviet delegation fully supported the draft resolution.

Mr BOBAREVIC (Yugoslavia) said that his Government's position on the subject under discussion was well known and needed no further elaboration. The Yugoslav delegation fully supported the draft resolution and wished to be a co-sponsor.

Mr ABBASSI TEHRANI (Islamic Republic of Iran) said that his Government was opposed to all forms of racial discrimination and apartheid and fully supported the liberation struggle in southern Africa. His delegation wished to co-sponsor the draft resolution, and hoped for its unanimous approval.

Mrs WOLF (German Democratic Republic) said that her Government firmly supported the States seeking peace and security and the establishment of propitious conditions for the consolidation of their domestic development. It also pledged unrestricted solidarity with the Namibian people's struggle for freedom and independence and the South African people's struggle against the disgraceful system of apartheid. In his message to the United Nations Secretary-General on the occasion of the 1985 International Day for the Elimination of Racial Discrimination, the Chairman of the Council of State of the German Democratic Republic had pointed out that the people and Government of his country opposed with disgust and indignation the practices of the racist and fascist regime in South Africa, whose policy of State terrorism seriously endangered international peace and security, and that they condemned efforts to preserve the criminal apartheid regime as an instrument for destabilizing the region and preventing social progress.

In addition to political and moral support, the German Democratic Republic provided extensive material assistance to the States and peoples concerned. From 1975 to 1983, aid to the peoples and liberation movements of southern Africa had totalled approximately US$ 200 million; assistance to the front-line States, SWAPO and the African National Congress (ANC) had amounted to 40 million marks in 1983 alone, and in the past year several million marks had been raised to finance treatment and care in its health establishments of wounded patriots and fighters belonging to liberation movements, victims of imperialist and country-revolutionary acts of aggression and terror.

The German Democratic Republic appreciated the activities of WHO over the years in support of the front-line States and national liberation movements. Those activities were an expression of what the Organization could do, and they should be continued as long as necessary. Her delegation supported the draft resolution before the Committee.

Mr NGUTA (Kenya) welcomed the assistance given to the front-line States, whose efforts towards health for all suffered from unfair and deliberate interference and destabilization engineered by the racist regime of South Africa.

Kenya supported the struggle of the front-liners and felt strongly that effective and sustained assistance should be afforded them by all peace-loving States. Kenya wished to co-sponsor the draft resolution and urged delegations to give it their unanimous support.

Mr RUMJANEK CHAVES (Brazil) said that the Brazilian Government had constantly spoken out in the United Nations and other international organizations in favour of the liberation of the peoples of southern Africa, and against apartheid, and once again expressed its support for any action aimed at ending the racial discrimination and illegal occupation of Namibia. It also supported all programmes to establish or strengthen cooperation with the newly decolonized States in southern Africa and had done everything in its power to intensify such programmes multilaterally or bilaterally, particularly in the Portuguese-speaking countries. The guidelines established for those programmes had been conceived to meet the specific needs of those countries and to effect the transfer of technology and the training of staff.

Long-term and short-term technical assistance in public health, epidemiology, parasitology and the control of research into malaria and other prevalent endemic diseases was the aim of such cooperation.

Mr HOSSAIN (Bangladesh) said that his country's policy on the South African racist and apartheid regime was well-known and needed no further elaboration. His delegation fully supported the draft resolution and hoped that it would be adopted by consensus.
Dr SEBINA (Botswana) welcomed the report on progress; world pressure seemed to be having some effect. He also noted the support that had been expressed for refugees from the ravages of apartheid. He said that help in consolidating the health infrastructure of Botswana was needed, as resources had been diverted to provide security and protection for refugees from Angola and South Africa who continued to live in fear. He mentioned recent incidents in which attacks had been made on a house sheltering refugees and a car occupied by refugees. The final solution to the problem was the abolition of apartheid, whose effects on health were well described in the WHO report on the subject.¹

Mr BOYER (United States of America) commended the action taken by the new Regional Director for Africa, which would benefit all the African Member States. He said that, although respecting the strong feelings expressed by many of the African nations, he regretted the inclusion of unnecessary political rhetoric in the text of the draft resolution. He found it curious that countries which now supported a boycott on South Africa had not earlier opposed a resolution condemning economic sanctions. He sympathized with the health problems of the front-line States, Lesotho and Swaziland and hoped that it would be possible in the following year to draft a resolution that could be adopted by consensus. He called for a vote on the draft resolution.

Dr NKWASIBWE (Uganda) said that the draft resolution was important not only because it called for assistance to the front-line States in their struggle against the obnoxious activities of racist South Africa, but also because it opposed the exploitation of man by man. He said that the racist regime would not survive if it were not sustained by trade with certain countries and provided with the financial means to buy guns to kill blacks in their own land. He called for an end to such support and asked that funds be diverted to liberation movements for the assistance of displaced persons. He appealed for unanimous support for the draft resolution as a demonstration of solidarity.

Professor MALEEV (Bulgaria) said that his country had long maintained the same position regarding the political aspects of this question and had expressed it in WHO and other organizations of the United Nations system. He supported the draft resolution and thanked the Director-General for his continuous efforts to provide health assistance and, thus, moral assistance to the front-line States and to the liberation struggle in southern Africa.

The draft resolution was approved by 96 votes to 1, with 8 abstentions.²

Mr PINTO DE LEMOS (Portugal), Mrs VAN DRUNEN LITTEL (Netherlands), Mr DE BURGER (Canada), Miss RIDDELL (New Zealand), Mr CAMPBELL (Australia) and Mr CAMBITISIS (Greece) explained that, although voting in favour of the draft resolution because of their support for assistance to the front-line States, Lesotho and Swaziland, they deeply regretted the use of inappropriate, politically-oriented language in the preamblary paragraphs.

Mr FORMICA (Italy), Mr CHAMPENOIS (Belgium), Mr BROCHARD (France) and Mr WUNDERLICH (Federal Republic of Germany) explained that, while supporting the spirit of the draft resolution, they had abstained because of the inclusion of unacceptable terminology.

Dr EL-SHERIF (Libyan Arab Jamahiriya) explained that he had voted in favour of the draft resolution because it reflected the true situation in southern Africa.

Emergency health and medical assistance to drought-stricken and famine-affected countries in Africa: Item 33.6 of the Agenda (Resolution WHA37.29; Document A38/16²)

Dr PARTOW (Assistant Director-General) introduced the report by the Director-General on emergency health and medical assistance to drought-stricken and famine-affected countries in Africa (document A38/16). The report represented the joint contributions of the Regional Offices for Africa and the Eastern Mediterranean, as well as of WHO headquarters. It indicated the response of WHO to the emergency needs of countries and WHO efforts in fostering self-reliant health development. The crisis in Africa had become so acute that it

² Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA38.28.
³ Document WHA38/1985/REC/1, Annex 5.
called for vigorous and intensive supportive action. The magnitude of human suffering was alarming, and urgent interventions were needed to alleviate such distress.

He recalled the action taken by the Secretary-General of the United Nations in setting up a special Office for Emergency Operations in Africa (OEOA). WHO had cooperated with that office since its establishment and had recently been asked to become a member of its Emergency Task Force. WHO coordinated its health-sector activities closely with UNICEF, which was also a member of the Task Force. As the report stated, WHO also collaborated with the United Nations Disaster Relief Coordinator, UNHCR and many international and nongovernmental organizations.

WHO was strengthening its readiness to respond to emergencies. For example, country-level support had been intensified and WHO programme coordinators and representatives had been more actively involved in emergency relief operations, particularly in the identification of health needs, in conjunction with OEOA, UNICEF, and UNDP. Special mechanisms to coordinate regional efforts had been set up in the regional offices concerned, and a technical task force had been established at WHO headquarters to facilitate access to the technical advice and support needed in emergencies. WHO constantly updated the information required to deal with the situation as effectively and efficiently as possible.

The report did not cover specific country needs for future support which were systematically assessed and analysed, the necessary action being taken jointly with other agencies and organizations. WHO was mindful that resources should be used by countries to enhance self-reliance, instead of continued dependence. WHO and other resources were, after all, finite and time-limited. Increasing self-reliance would have a long-lasting effect on health development and would improve countries' readiness to cope with future emergencies.

As the Director-General had stressed, the deterioration in the health situation in Africa could not be arrested by one-time charity actions, but only by substantial support to development. Emergency aid should therefore be matched by long-term support for health development. WHO was both strengthening the capacity of its emergency relief operations at all levels and making every effort to relate them to the necessary developmental follow-up.

Dr TSHABALALA (Swaziland) said that the unprecedented drought and famine in the African Region had affected millions of lives. Men, animals and plants had been victims of the current economic and social crises in Africa, and the migration of millions of refugees and displaced persons has placed an additional burden on the insufficient medical, health and social services. The report by the Director-General had noted "the displacement of many thousands of people into overcrowded camps, often in areas already stricken by drought" (paragraph 3). There were critical shortages and, at times, a total lack of food and water. The extremely poor sanitary conditions gave rise to malnutrition, anaemia and outbreaks of diseases such as cholera and malaria.

She introduced the following draft resolution:

The Thirty-eighth World Health Assembly,
Deeply concerned with the serious economic crisis in the African continent, affecting a large number of countries which are facing drought, food scarcity, and stagnation and even retardation in the development process;
Recalling United Nations General Assembly resolutions 38/199 and 38/200, and particularly taking into account resolution 39/29 and the Declaration on the Critical Economic Situation in Africa;
Further recalling Health Assembly resolutions WHO36.29 and WHO37.29 and Executive Board resolution EB75.R14;
Expressing the non-aligned and other developing countries' solidarity and deep sympathy with the crisis-affected people of Africa, and recalling that the ministerial-level meeting of non-aligned countries held in New Delhi in April 1985 called for intensified efforts and generous responses to the requirements of emergency needs and medium- and long-term development programmes;
Taking into account the Director-General's report on the African crisis situation and noting with satisfaction the action taken by the World Health Organization in its humanitarian response to the serious health-related situation of the crisis in Africa;
Emphasizing the necessity of an integrated response linking emergency measures with the long-term development perspective for effectively dealing with the situation;

1. CALLS UPON the international community, including bilateral donors, United Nations organs and organizations, specialized agencies and nongovernmental organizations and others, to pursue its relief efforts vigorously to deal with the crisis in a coordinated and concerted manner, taking fully into account the imperative need to link these initiatives and efforts with the long-term development perspective;
2. REQUESTS Member States and the affected countries to do all they can to facilitate and coordinate all relief, rehabilitation and development efforts;

3. URGES the Director-General and the Regional Directors concerned to continue their unrelenting efforts to cooperate with the governments of the affected African Member States to respond to the health consequences of the crisis as an integral part of the regional and global strategies for health for all, particularly taking into account the need to intensify WHO's technical cooperation at the country level to enable the Member States to enhance their disaster preparedness and prevention capabilities;

4. REQUESTS the Director-General:
   (1) to review the situation in collaboration with the countries concerned and take appropriate measures to mobilize additional resources for assistance to these countries;
   (2) to report on the action taken to the Thirty-ninth World Health Assembly.

The draft resolution would be amended to incorporate the contents of a similar draft resolution dealing with Somalia, with the agreement of the co-sponsors of that draft resolution, which would be withdrawn. The title should be amended to cover emergency health, medical and social assistance to countries in Africa affected by drought, famine and other disasters.

She drew attention to a few minor amendments to the draft resolution as originally presented. The title should be amended to read "Emergency health, medical and social assistance to drought, famine and other disaster-affected countries in Africa". The first preambular paragraph, after the phrase "food scarcity", should be amended to read "... problems of refugees, returnees and displaced persons, and retardation in the development process". In the fourth preambular paragraph, before the word "solidarity" the phrase "as well as the international community's" should be added. Finally, the last line of operative paragraph 3 should be amended to read "... disaster preparedness, including measures to prevent and manage malnutrition, anaemia and outbreaks of disasters such as cholera".

She hoped that the draft resolution, as thus amended, would be adopted by consensus.

Mr SHENKORU (Ethiopia) thanked the Director-General for the information provided in his report, and fully endorsed the statement made by the delegate of Swaziland.

The report described the current economic and social crisis in Africa and the action taken, as well as the needs for the future, within WHO's area of competence. In Ethiopia the Organization, working in collaboration with government authorities and with the United Nations special representative, had made an estimate both of the funds needed for equipment of health centres and of health manpower and training requirements, as well as planning a nutrition programme. Since 1982, WHO had been collaborating with UNICEF and other agencies to improve sanitary conditions in the transit centres and camps for displaced persons.

He hoped that WHO would intensify its assistance in order to help alleviate Ethiopia's current problems, and that donors would respond positively by giving generously to meet the country's needs as they were set out in the document submitted to donor countries and agencies in January 1985.

Dr NAKAMURA (Japan) felt deep sympathy for the drought-stricken people of Africa, and considered that the current unprecedented situation should be tackled by all members of the international community, not only WHO. Japan had repeatedly stressed the need for assistance to Africa, and had strengthened its own efforts to bring aid to the region.

At the second International Conference on Assistance to Refugees in Africa, Japan had pledged some US$ 6 million of cash aid and some US$ 6.5 million of food aid, all of which had now been disbursed; the development projects which it was sponsoring were moving steadily towards implementation. He pointed out that in 1984 some 60% of Japan's total food aid had been destined for Africa; in addition, a further US$ 50 million in food and agricultural assistance had been provided. Four emergency medical missions had been sent to Ethiopia between December 1984 and March 1985 to provide relief to the drought-stricken people.

At the Conference on the Emergency Situation in Africa held in Geneva in March 1985, Japan had stated its intention of making further efforts to help overcome the difficulties facing African countries. It intended to provide some US$ 240 million in bilateral assistance to Sub-Saharan Africa, and to provide approximately US$ 100 million in loans in cooperation with the World Bank and other international financial institutions, the loans to be linked with technical assistance. A number of nongovernmental organizations in Japan had also been active in providing aid to Africa by donating blankets, raising funds, and sending volunteer medical staff to the field.
The draft resolution stressed the need to link emergency assistance to development cooperation. His delegation wished to emphasize the need for both medium- and long-term assistance to African countries in their efforts towards rehabilitation and development.

Cooperation between donor and recipient countries, as well as coordination of related United Nations activities, were essential if the problems of the African countries were effectively tackled. He hoped that WHO would continue to make its contribution. Japan would continue to meet its commitment as a responsible member of the international community.

He supported the draft resolution with the amendments proposed by the delegate of Swaziland.

Mr ISMAIL (Sudan) thanked the Director-General for his continuing efforts to alleviate the suffering of African countries affected by famine and drought, and expressed his appreciation for the information given in the report. He thanked donor countries and donor organizations that had worked together with WHO to strengthen the ability of drought-stricken countries to meet the health needs of their people. The drought belt extended from the shores of the Atlantic to the horn of Africa, and some 30 million people in the region were threatened by famine, malnutrition and communicable diseases. Some 10 million Africans had been displaced from their homes to other areas in a desperate search for food, water, health care and pastures for their cattle. The continuing drought had further aggravated the already serious economic problems of the continent, forcing many States to forgo the implementation of their development plans because of the overriding need to provide sufficient food to keep their people alive.

Sudan had suffered from a drought crisis since 1980. For four years the lack of rainfall and the consequent drop in agricultural output had resulted in some 4.5 million people suffering from famine, malnutrition and the spread of communicable diseases. A large number of them had migrated to other regions, only to find that they too were equally affected by the drought. The effects of the crisis had been compounded by the waves of refugees crossing the borders from neighbouring countries.

He wished to thank WHO for the massive efforts it had made to provide assistance to the Sudan in an attempt to prevent any further deterioration in the health situation of the population. In particular, he wished to thank the Regional Director for the Eastern Mediterranean for the prompt response he had made to meet the health needs and problems of the area.

The results of the Conference on the Emergency Situation in Africa and the follow-up to resolution WHA37.29 had been very encouraging. The Conference had succeeded in providing about US$ 1200 million to meet the emergency needs of 20 of the drought-stricken and famine-affected countries in Africa. That success was due to the generous support of the international community, and he wished to thank all donor countries and international organizations that had contributed. He hoped that that support would continue, both in the medium and long term, so that the African countries affected would be able to find radical solutions which would guarantee their economic development.

He fully supported the draft resolution, together with the amendments proposed, and urged the Committee to give it its unanimous support.

Mr SANGARE (Mali) paid tribute to the high quality of the Director-General's report. Mali had for more than a decade been among those countries which had suffered from the terrible drought. Unfortunately, each year that passed seemed to produce a new challenge, and, as the report indicated, the situation did not seem likely to improve in the near future. Confronted by a catastrophe of such an immense scale, his country had appealed for international solidarity in support of its efforts in the unequal combat in which it was engaged. He was glad to say that that appeal had in large measure been answered and that friendly countries, international organizations and nongovernmental organizations alike had continued to give proof of concern and material and moral solidarity.

He wished to express Mali's deep gratitude for the very considerable efforts made by the international community, but stressed that those efforts would be vain unless the governments and peoples of the countries concerned themselves contributed efforts of their own. That point was too often overlooked, and he would like to see it stressed in future reports. It was for that reason that his own Government was currently striving to mobilize national efforts in order to plan and implement strategies and programmes to combat the drought, which had henceforth to be considered as a permanent fact of life.

The health of populations was one of the chief preoccupations of any development programme, and more especially where disaster situations were concerned. In the past year his Government had paid special attention to combating the health consequences of the drought, and notably the epidemics from which his country had suffered. The normal resources of the national budget had been severely strained by the measures needed to deal with such
urgent problems, and the Government had accordingly devised long-term strategies in regard to such programmes as the Expanded Programme on Immunization and those on nutrition, diarrhoeal diseases, and drinking-water supplies, all of which were currently of a special concern. He was glad to state that as a result of the efforts of the international community, notably WHO and UNICEF, some of those programmes had already begun to be implemented, although unfortunately many of them suffered from a lack of funds. He was grateful for the contribution already made by the Organization, and urged that its efforts be intensified.

He fully supported the draft resolution and asked to be included among its sponsors.

Dr PARTOW (Assistant Director-General) said he hoped the delegate of Swaziland would find it acceptable if a small change was made in the wording of the amendment she had proposed for operative paragraph 3 of the draft resolution. It had been the consensus of a majority of WHO Member States, a consensus subsequently expressed in WHO policy, that cholera should not be considered as a disaster, but rather as a diarrhoeal disease, which health authorities now had the tools to control. He therefore suggested that the phrase "outbreaks of disasters such as cholera" should be replaced by the phrase "outbreaks of epidemics": that wording would cover all epidemics, of which cholera was now not the most significant or serious.

Dr TSHABALALA (Swaziland) said that the delegations of countries of the Non-aligned Group could accept that amended wording.

The meeting rose at 11h10.
Emergency health and medical assistance to drought-stricken and famine-affected countries in Africa: Item 33.6 of the Agenda (Resolution WHA37.29; Document A38/164) (continued)

Mrs GREWAL (India) said that the drought in Africa had affected some 30 million people in 20 countries; over 10 million people were reported to have abandoned their homes in search of food. The international community must give its full support to WHO in mobilizing health and medical assistance.

The Government of India had announced a gift of 100,000 tons of wheat for Africa which was being distributed with the help of the World Food Programme; India had also made commitments to supply medicine and health equipment. As Chairman of the Non-aligned Movement India had been instrumental in setting up an action committee which had drawn up a Draft Plan of Action to meet the critical economic situation in Africa. The Draft Plan of Action had been adopted at the Extraordinary Ministerial Meeting of the Coordinating Bureau of Non-aligned Countries in April 1985; India was to serve as a focal point for the implementation of the Plan of Action. Her Government would also endeavour to increase substantially its assistance to the affected countries within the framework of its technical and economic cooperation programmes and had decided to make a contribution to the Organization of African Unity Special Emergency Assistance Fund for Drought and Famine in Africa.

Her delegation wished to thank the Director-General for his comprehensive report on the action taken by WHO and for mobilizing all possible support for the drought-stricken and famine-affected countries in Africa. The draft resolution on emergency health and medical assistance had received the full support of the Ninth Meeting of Health Ministers of Non-aligned and Other Developing Countries, and her delegation hoped that it would be adopted unanimously.

Mr DWYRE (United States of America) said that his delegation appreciated WHO's work on disaster relief and preparedness within the context of primary health care. At the meeting of the Executive Board in January 1985 there had been some confusion about the appropriate role for WHO in emergency relief situations but his delegation believed that progress had been made in clarifying that role. The Director-General's opening statement during the current Health Assembly, together with the description contained in document A38/16 and the comments made by Dr Partow at the ninth meeting of the Committee, had been very useful.

The United States delegation nevertheless felt that WHO assistance in past emergencies might not have been as rapid as the circumstances warranted. The Director-General should work continuously to ensure that the reaction of WHO to health emergencies in developing countries, especially the least developed, was both appropriate and timely. The draft resolution on emergency health and medical assistance reinforced that point of view and his delegation would be pleased to support it. The delegate of Swaziland had rightly noted that the "deep sympathy with the crisis-affected people of Africa" referred to in the fourth preambular paragraph was not felt merely by the non-aligned and other developing countries. The entire international community shared that sympathy, as had been demonstrated by the generosity of many countries, and the United States delegation would therefore support the amendments proposed by the delegation of Swaziland.

Noting that the Director-General had taken steps to buttress the Emergency Relief Operations office with a standing task force drawn from technical divisions at WHO headquarters and that steps had been taken to restructure and strengthen the Regional Office
for Africa, he said that those actions should improve the Organization’s capacity for making rapid and specialized assessments of health problems in emergency situations when urgent advice might be needed on such matters as nutritional deficiencies, sanitation conditions, epidemiological information and the consequent needs for medical supplies, drugs and transport. WHO had a central role to play in that large and complex area in close coordination with the United Nations Office for Emergency Operations in Africa and in continuous liaison with UNDRO, UNICEF, the League of Red Cross and Red Crescent Societies, and the United Nations, as well as with bilateral and nongovernmental assistance organizations. It should indeed continue to work closely with those organizations to help clarify channels of communication with the governments of disaster-stricken countries.

In conclusion, the United States delegation would urge WHO to assume greater leadership in assisting developing countries to deal with the health effects of disasters. Whenever it was possible to foresee a disaster situation, he hoped that WHO would send highly qualified persons or teams to advise on health and medical preparedness. Such WHO consultants and teams, financed when appropriate from extrabudgetary contributions and organized in concert with UNDRO and other international organizations, could contribute significantly to enabling the developing countries, particularly the drought-affected countries in Africa, to continue their development programmes and to maintain momentum in extending primary health care to all their people.

Mr MOHAMMAD (Nigeria) said that his delegation wished to be considered as a co-sponsor of the draft resolution on emergency health and medical assistance. It also wished the Thirty-eighth World Health Assembly to regard Nigeria as a drought-affected State for the following reasons: approximately two-thirds of the country was affected by drought; as a result, rinderpest had killed and continued to kill a substantial proportion of the cattle population; and Nigeria during the previous three to five years had experienced an unprecedented influx of people from drought-affected areas in other countries.

He was happy to note that WHO was constantly reviewing the situation with a view to providing substantial support for development in drought-affected States. He hoped that the Health Assembly would unanimously endorse both the Director-General’s report and the draft resolution as amended.

Mr AL-HADDAD (Kuwait) said that his delegation sympathized with the drought-stricken and famine-affected countries of Africa. He therefore requested that Kuwait be added to the list of co-sponsors of the draft resolution as amended by the delegate of Swaziland.

Mr Joun Yung SUN (Republic of Korea) fully supported the efforts of WHO to provide emergency health and medical assistance to the drought- and famine-affected countries in Africa. It fully subscribed to the view expressed in the Director-General’s report that it was very important for WHO to give high priority to long-term support for health development in those regions as a means of eliminating so much human suffering.

In late 1984 and early 1985 his Government had provided the affected countries with emergency relief to a value of US$ 500 000 together with medical and other relief items totalling US$ 1 000 000. The amounts might be comparatively small but they represented an expression of friendship and cooperation on the part of the people and Government of the Republic of Korea. Voluntary donation campaigns were being carried out by the Korean Red Cross Society and other organizations and were expected to continue indefinitely.

Mr TOMO (Mozambique) said that his country was among those most seriously afflicted by the five-year drought. Drought, cyclones and earthquakes were natural disasters which could strike anywhere, but their consequences varied with the degree of development of each country. In developed countries, where facilities existed for predicting and providing against natural disasters, their impact was minimal. In developing countries such as Mozambique, which lacked human, technological and financial resources and was moreover the victim of an organized international conspiracy, the smallest change in the balance between man and nature could have disastrous consequences.

In Mozambique, drought and famine were seriously affecting 2.5 million people including 387 000 children below five years of age. Characteristic of conditions in Mozambique were: a water shortage due to lack of rain; loss of cattle consequent upon the shortage of water and grazing; the need for people to walk for miles in search of water, thus depleting their strength and aggravating the effects of famine; and population movements within the country and to neighbouring countries in search of food.

The Government, with the support of the international community, had taken emergency measures to combat the situation, including: distribution of basic food supplies; provision of supplementary and therapeutic food supplies to nutritional rehabilitation centres in the regions most affected; the establishment of small rural projects with the organized and
active participation of the population, covering water, health and nutrition, with a view to stimulating self-sufficiency in food production. An expanded system of nutritional surveillance was to be adopted. Provision had been made for developing agricultural information comprising indicators on food safety and availability and on migration. Special attention was being given to the displaced population by making land, agricultural implements and seed available to them, while children, particularly orphans and abandoned children, would be given appropriate assistance in newly created centres.

The drought-related famine problem in Africa would not be solved by food distribution and the nutritional rehabilitation of its victims. Among basic requirements were appropriate technology and drought-resistant crops at both the global and national levels.

At the United Nations Conference on the Emergency Situation in Africa, held in Geneva in March 1983, Mozambique had submitted a report, together with project recommendations covering specified sectors where immediate short-term assistance was needed. His delegation appealed to Member States to make every effort to save the victims of drought and famine in Africa, and to adopt the draft resolution presented to the Committee, together with the proposed amendments.

Mr VIGNAUD (Food and Agriculture Organization of the United Nations) said his Organization's approach to the problem of drought and famine in Africa was entirely consistent with the view expressed by the Director-General of WHO to the Health Assembly in plenary that emergency aid was not a long-term solution and at the most represented only an alleviation with the risk of creating social and economic dependency. In the final analysis people must be helped to feed themselves. FAO therefore maintained that emergency food aid should be accompanied by measures aimed at reviving devastated African agriculture and converting it from a state of dependency to a state of production.

In a large part of the African continent, particularly in the affected countries, there was a potential for increasing agricultural and livestock production. Even in a normal year, however, the majority of those countries had been producing well below the maximum made possible by modern techniques such as improved seed varieties, the use of fertilizers and insecticides and better farming practices. The rehabilitation effort should therefore extend to a wide range of measures designed to restore the capacity to produce crops, livestock and fisheries in the areas of Africa which had been most seriously affected.

FAO had identified a series of projects for agricultural rehabilitation to be implemented in 21 affected countries over a period of one to three years. The international community had given that initiative a favourable reception and it was likely that there would be donor countries to finance the rehabilitation projects.

At the end of April 1983, the food supply situation was continuing to deteriorate in several of the 21 countries which FAO considered to be facing an emergency food situation. Although weather conditions had in general been favourable to crops in some countries in the southern part of Africa, several of them would continue to face exceptional food shortages in 1985 and 1986. In Western Africa logistic constraints were impeding the distribution of food in several countries where the situation was already critical. In Eastern Africa the prospects for crops were generally favourable. However, the situation was continuing to deteriorate in Ethiopia and Sudan where widespread malnutrition and deaths from starvation were reported. Only concerted action by the international community and the Governments of the affected countries in the coming weeks could avert major disaster in the most seriously affected countries.

Food aid requirements for the 21 most affected countries had been estimated by FAO to be 7 million tons, which was more than double the amount received by the same countries during the period 1983-1984. Up to the end of April, pledges reported to the FAO Global Information and Early Warning System amounted to 6.3 million tons. However, a cause of major concern was that only 2.7 million tons of the 6.3 million pledged had actually been received in the affected countries. It was therefore necessary to expedite implementation of the pledges already made and also to solve the problems of transport and distribution which might arise in order to avoid a crisis of even greater proportions. Another matter which required urgent solution by the international community was the supply of seeds and other inputs required for planting in May and June. In fact, in several countries seed supplies were well below the minimum required.

Additional information was available on request, but he would conclude on a note of optimism: the international community had in general reacted in a generous way to solving the problems faced in the African countries affected by the drought, and it was to be hoped that the concern expressed by WHO and the warning given by FAO in its report would evoke a widespread response. The recent summit meeting in Bonn strengthened that optimism, since the participating governments had committed themselves there to continuing emergency food aid and intensifying their cooperation with the African countries by helping them to achieve their own economic potential and a long-term food strategy based on the development of their own agriculture.
Mr BOBAREVIC (Yugoslavia) welcomed all the efforts being made to solve the urgent problems of the drought-stricken and famine-affected countries in Africa and commended the Director-General on his comprehensive report. At the thirty-ninth regular session of the United Nations General Assembly, Yugoslavia had supported the adoption of the Declaration on the Critical Economic Situation in Africa, considering it to be an expression of the will of the international community to conduct joint action to solve the current and long-term problems of the African continent.

At various meetings of non-aligned and other developing countries Yugoslavia had expressed its solidarity and deep sympathy with the crisis-affected people of Africa. The Government was making efforts to provide, within the limits of its possibilities, assistance to and cooperation with African countries in order to satisfy their needs and achieve more rapid development. In addition to economic assistance to African countries to the value of US$ 36 million in the last five years and a further US$ 3 million in humanitarian assistance, his country would support all urgent and coordinated action by WHO and United Nations agencies and other organizations, directed in such a way that both emergency aid and assistance for medium- and long-term economic and social development would be provided with the highest possible priority. Particular priority would be given to activities based on technical cooperation at the country level to enable Member States to build up self-reliance and a self-sustaining process of health development.

Dr HACEN (Mauritania) expressed his country's thanks for the very valuable support given by WHO and other organizations of the United Nations system as well as by many governments and nongovernmental organizations. That support in such difficult circumstances was an expression of the deep feeling of solidarity among all the peoples of the world. He shared the view that emergency aid should be coupled with the implementation of global policies for development in each country. His delegation supported the draft resolution with the proposed amendments and wished to be added to the list of co-sponsors.

Mrs HU Sixian (China) said that the severe hunger in some African countries caused by the prolonged drought had aroused great concern in the international community, as had been demonstrated by the Declaration on the Critical Economic Situation in Africa unanimously adopted by the United Nations General Assembly. The United Nations Conference on the Emergency Situation in Africa, held in March 1985, had discussed active measures to be taken to deal with the critical situation. There had been a worldwide response from all countries and international organizations, and a global movement to assist the drought-stricken African countries had emerged. The Government and people of China had always shown great concern at the serious situation produced by the drought in the African countries. The Government had decided that, in addition to its contribution of 120,000 tonnes of grain in 1984, it would allocate another 50,000 tonnes in the first part of 1985 as urgent aid. It would also provide assistance in the form of farm tools, vaccines and other essential drugs. Countless individuals, young and old, had volunteered to make personal monetary contributions to the afflicted African countries. The Government had recently sent medical teams to Africa in order to help local communities overcome their medical problems and cope with various diseases.

The Organization of African Unity had adopted in 1984 a solemn declaration on economic issues together with a series of important resolutions which demonstrated the will of the African countries to work with solidarity and cooperate in economic development. The industrious, brave and intelligent African people, through their heroic struggles of past years, had achieved great victories in attaining national independence against the forces of imperialism and colonialism. Africa's peoples, with support from the international community, would rely upon their own painstaking efforts to overcome all the difficulties and build a new vigorous and prosperous Africa.

The Chinese delegation supported the draft resolution with the proposed amendments.

Mr ABBASSI TEHRANI (Islamic Republic of Iran) said that his country wished to express its deep sympathy with the drought-stricken and famine-affected countries of the African continent. It had participated in the Extraordinary Ministerial Meeting of the Coordinating Bureau of Non-aligned Countries in New Delhi in April 1985, where a call had been made to intensify efforts to meet the emergency needs of African countries suffering from a serious economic crisis. The Member States of WHO, and of other international organizations and agencies, should respond to that call. He referred to the continuing assistance given to some African countries by the Red Crescent of the Islamic Republic of Iran. His delegation wished to be included in the list of co-sponsors of the draft resolution before the Committee.
Dr UNTORO (Indonesia) expressed appreciation of the Director-General's report. It was very important not only to support emergency measures but to emphasize the systematic long-term health development of the disaster-stricken countries. Her delegation was gratified by the concerted efforts of WHO and other specialized United Nations bodies concerned with development to ensure that immediate requirements to save lives were met. It fully supported the draft resolution with the proposed amendments.

Mr CHANSHI (Zambia) expressed gratitude to the international community for the support provided during the disaster affecting his country. Zambia had experienced the natural catastrophe of drought for the first time as an independent and sovereign State and was facing all the difficulties of learning how to cope. The Government had conducted a survey in 1984 in conjunction with WHO and UNICEF to assess the impact of the four-year-old drought on health and had discovered an alarming and complex relationship between drought and the health situation of the population. The incidence of schistosomiasis, eye disease, skin infections, tuberculosis, malnutrition and malaria had proved to be much higher in the more severely drought-affected areas than elsewhere. There were indications that more insidious and subtle psychosocial problems might well be developing. It was to be hoped that the current good rainy season was a sign of a return to normality, since any further drought would mean deferring plans and action designed to reduce considerably the adverse affects already identified. Mindful of the fact that the effects of drought were cumulative and continued long after the drought was over, his delegation requested those countries providing emergency aid to continue to support Zambia until it was able to deal with the situation alone. The national strategy for immediate action included urgent improvement in the distribution and supply of essential drugs, especially for the diseases mentioned earlier; improvement of water supplies by the provision of water wells and, where necessary, mobile water supply vehicles; an early warning system for predicting drought; a surveillance and monitoring mechanism to observe the effects of drought especially as they related to the diseases identified; improvement of the availability of food supplies in order to cope with the current food shortage in the worst affected districts. In the long term the Government was accelerating implementation of the ten-year plan and had also embarked upon alternative irrigation options. Stress was being laid on research into drought-resistant and fast-growing strains of the country's major staple crops. Access roads were being improved in order to give better haulage of crops so as to minimize wastage. In all those activities, Zambia would need the help of the international community, including the United Nations system.

His delegation wished to support the draft resolution and the proposed amendments.

Dr EL GAMAL (Egypt) expressed his country's appreciation of the help given by WHO to the drought-stricken countries in Africa. For its part, Egypt had provided rapid help with food and medical services to those African countries requesting them. It fully supported the draft resolution and the proposed amendments. He asked for further information concerning the alarming statement by the FAO representative that logistic constraints were impeding the distribution of food to target populations in several countries.

Dr DE CARVALHO (Cape Verde) said that Cape Verde, a State belonging to the Sahel region whose struggle to implement its development policy was being complicated by drought, wished to be added to the list of co-sponsors of the draft resolution and supported the proposed amendments.

Mr AOUN-SEGHIR (Algeria) said that the Director-General's report gave an excellent account of the problems Africa was facing. The continuing world crisis and the persistent drought had so affected the economies of African States that sheer survival of their peoples had become the major concern, legitimate aspirations towards development being relegated to second place. The food situation had reached a critical threshold, with continuing expansion of the famine-affected areas. As the report pointed out, the first priority was obviously food; but it was gratifying to note that WHO also placed emphasis firmly on development. Another welcome point was the high priority being given by international organizations to the economic and social situation in Africa and the recognition accorded by the international community to the need to provide long- and medium-term development assistance; for their part, the African countries were fully aware that the responsibility for their economic recovery lay primarily with themselves. Nevertheless, massive and continuing international support was needed if Africa was to cope with its severe economic problems and at the same time reform its economic structures.

Algeria, itself a developing country, had for a number of years been expressing its solidarity with other African countries by devoting 1% of the gross national product to development aid. It had made an extra effort in addition to provide assistance in cash and
in kind to the countries affected by drought and famine, as well as initiating joint action to deal with the emergency. Algeria would continue its efforts at the bilateral, regional and international levels towards finding solutions to Africa's economic problems. The Director-General was to be commended for the interest he had shown in the plight of the continent, and thanked not only for the programmes he had launched in many African countries but also for his personal efforts to encourage the international community to provide further assistance for Africa.

Mr. HOSSAIN (Bangladesh) expressed his delegation's appreciation of the Director-General's report and its presentation. Bangladesh fully endorsed the view that a single charitable effort could not solve a problem of such magnitude caused by the vagaries of nature; a long-term programme was required. The Committee would recall that the Director-General, in his address to the third plenary meeting, had said, "... charity is never a lasting solution. At best it alleviates; at worst it subjugates". That was an incontestable truth. Nevertheless the Organization had, true to its tradition of dedication and dynamic leadership, met expectations by embarking on wide-ranging measures to meet the emergency health situation in the affected countries of Africa.

Bangladesh was a country subject to the whims of nature and had itself suffered famine a decade before. It thus had a deep understanding of and sympathy with the sufferings of the people of the drought-stricken and famine-affected countries of Africa. The lives of millions of people were in the balance and the immediate task was to save them. As for medium- and long-term action, Bangladesh endorsed the report's view of the need for health infrastructure development, side by side with short-term measures. The present impetus for assistance to the affected countries in Africa should be used to help attain the ultimate goal of health for all by the year 2000.

The Bangladesh delegation supported the draft resolution and proposed amendments, and hoped they would be adopted unanimously.

Mrs. ENO-HASSAN (Somalia) joined in expressing appreciation of the Director-General's report, which clearly reflected WHO's commitment to human solidarity and the will to contribute to the endeavour to alleviate the suffering of the victims of calamities.

The sympathy expressed in the Committee with regard to the critical situation in Africa was gratifying. In view of the fact that the draft resolution now entitled "Emergency health, medical and social assistance to drought-, famine- and other disaster-affected countries in Africa", of which Somalia was a co-sponsor, covered the whole range of problems at present affecting Africa as a result of the drought, Somalia, after consultation with OAU Member States of WHO and other co-sponsors of the draft resolution entitled "Health, medical and social assistance to Somalia", had decided to withdraw that resolution. The cholera outbreak in Somalia that had inspired the appeal was unfortunately also now affecting many other African countries, all of which should receive the attention and contributions necessary to combat the disease. WHO and the international community were well aware of health problems where they existed and could be trusted to provide appropriate assistance in any emergency situation.

Somalia had been the country hardest hit by the recent cholera epidemic, which had been particularly severe among the refugee camps in the north of the country where one-third of the thousands affected had died. That outbreak, thanks to a rapid response by the international community working jointly with the Somali Government, appeared to have been brought under control, but there was concern lest the disease break out in other places. There was thus an urgent need for further action to prevent such spread and WHO was asked to continue its support in the matter. Furthermore, the outbreak of cholera in the refugee camps had been followed by cases of malnutrition, anaemia and pneumonia among the refugee population. Deaths from those diseases were now outnumbering those from cholera.

The Somali Government was grateful to the international community for its support and was deeply appreciative of the action taken by the Director-General and the Regional Director for the Eastern Mediterranean and the support they had provided. It was hoped that the Regional Office would continue its cooperation with Somalia on health development programmes and the alleviation of the consequences of recurrent disasters.

Dr. DAOUDOU (Niger) said that for the past two years Niger had been suffering the worst drought in its history. Two and a half million people had lost all they had; 50% of crops had been lost, as well as considerable numbers of livestock. To cope with that situation, which had occurred at a time the world economy was in difficulties, the Niger Government had embarked on the development of areas with permanent water points or where water was relatively easily accessible. Half a million displaced persons were now involved in that project, which had 40,000 hectares under cultivation. Its produce was already making a significant contribution to food supplies and enabling people to subsist by their own efforts.
with a supplement provided by the Government, thus preserving their sense of their own dignity. Favourable changes in dietary habits were being made throughout the country. Efforts had also been made to salvage something from the livestock by means of projects for drying and preserving meat. An appeal for cereals had also been made to the international community and pledges for the supply of two-thirds of the 350,000 tonnes required had already been made. Niger was a land-locked and very large country and the transport of food supplies to their destination was a problem not yet entirely satisfactorily solved.

The health situation in Niger was under control as a result of the country's own efforts and with the support of WHO, friendly countries and the international community. Such efforts would need to become more rapid and flexible in execution, better coordinated, intensified and placed on a more permanent basis in order to prevent over-extension and collapse of the health system. The Organization's efforts to improve coordination between the affected and donor countries were therefore much appreciated. Those who had already made contributions were to be thanked and an appeal was made to them to increase their efforts not only to meet the needs of the emergency but also to help in developing health infrastructures with all possible speed so that the health system would emerge from the present testing period in a stronger position to face other possible disasters in the future.

Niger supported the draft resolution with the amendments proposed by Swaziland and wished to be included among its co-sponsors.

Mrs Luettgen de Lechuga (Cuba) said that although, Cuba was a developing country with limited economic resources, it had extended its cooperation to Africa as an expression of its solidarity with that continent, sending emergency assistance to remote areas. Among the many examples of such cooperation, mention could be made of the medical assistance provided in Ethiopia to families evacuated from drought-stricken areas, the basic activity being the control of cholera, typhus and other diseases. That action was in addition to the work of 300 and more health experts who had already been assisting the country for a number of years. Other countries, including Mali, Angola, Equatorial Guinea, Cape Verde, Benin and Burundi, had been given drugs and vaccines to help in the control of diseases such as cholera, typhus, leprosy and tuberculosis.

Twenty African countries in all, regardless of their political orientation, were receiving assistance from thousands of technical experts from Cuba in the fields of health, agriculture and education.

A proper solution to Africa's food problems, if a major ecological holocaust was to be avoided, demanded an intensive international effort in the form of cooperation and substantial investment.

The Cuban delegation expressed its solidarity with the drought-affected countries of Africa and wished to be included among the co-sponsors of the draft resolution before the Committee and supported the amendments.

Dr Ffloury (France) said that at the first sign of the threat to the 1983 harvest in a number of African countries as a result of the drought, France had taken steps to help its customary partners to deal with the situation. That assistance had mainly gone to countries in the Sahel, but efforts had also been made to provide assistance to particularly affected countries such as Sudan and Ethiopia. That action had also been greatly reinforced by direct aid from the European Community. French assistance was aimed at supporting action intended to achieve self-sufficiency in agriculture by strengthening development activities. In the health field, France was carrying out a number of community health projects in close collaboration with the countries concerned; those efforts involved about 1000 technical assistants in the health field, 700 of them physicians, some of whom had been providing emergency care in drought-affected areas. The drought was, unfortunately, a serious threat to the implementation of primary health care in the affected areas and was likely seriously to hold back community participation and financing. However, the drought-affected countries had themselves made enormous efforts to set up new structures to deal with the most urgent needs; some of which had been made possible through the cooperation of nongovernmental organizations, such as Médecins sans Frontières. Mention had been made of the danger of epidemics, notably of cholera, cerebrospinal meningitis and yellow fever, among people whose resistance had been reduced by malnutrition and population displacement. To combat that risk France had created a task force for rapid intervention with the necessary supplies and equipment in order to support national health services faced with such epidemics. The task force had already been in action several times, in particular in Guinea.

Dr Moucka (Zaire) welcomed the Director-General's report. Referring to the draft resolution before the Committee, as amended by the delegation of Swaziland, he expressed his compassion for the victims of the disastrous drought and famine situation in certain areas of Africa. Despite its own economic difficulties, which had been exacerbated by the world
WHO's approach to drought-stricken peoples giving them all crisis, Zaire had consistently shown its sympathy for the misfortunes of brother Africans by giving them all the emergency assistance it could provide in food and pharmaceutical supplies. His delegation wished to become a co-sponsor of the draft resolution, and it urged the Committee to do everything possible to promote urgent and adequate assistance to the drought-stricken peoples in Africa.

Mr SOKOLOV (Union of Soviet Socialist Republics), expressing support for WHO assistance to drought-stricken and famine-affected African countries, and welcoming the Director-General's report on the subject, said that such assistance would presumably be provided under the WHO regular budget as well as bilaterally. His country, which was deeply concerned at the difficult situation affecting African countries, was offering assistance, including drought and famine relief, to many of those countries. His delegation supported WHO's approach to the solution of their problems as outlined by the Director-General during the debate in plenary session. It also supported the draft resolution as amended.

Mr SAMARASINGHE (Sri Lanka) expressed support for the draft resolution as amended and said that his delegation wished to become a co-sponsor.

Mr GOGUS (Turkey), welcoming the Director-General's report, observed that the challenges currently faced by the African continent were complex and deep-rooted. No-one could remain unconcerned at the appalling situation prevailing in large parts of Africa.

While credit was due for the considerable efforts of African governments to overcome the serious situation, the African countries could not be expected to handle the problem effectively without substantial assistance from the international community, including international organizations. There was an obvious need for coordinated and continued action. The international community should step up its relief efforts rapidly and effectively. His delegation appreciated WHO's relentless efforts to alleviate the alarming health conditions in Africa.

While launching a new, urgent and comprehensive relief programme for Africa, the international community should take account of the long-term development needs of the stricken African countries, and global efforts should be made to promote a sustained development process in Africa.

On that understanding, he fully supported the draft resolution before the Committee.

Dr MOCHI (Italy) said that he had noted the Director-General's report with interest. Italy was carrying out a number of assistance projects in association with the drought-stricken Sahelian countries as well as projects in other areas of Africa, and hoped to be able to increase its support substantially in the near future. In its cooperation in the health field, it endeavoured to integrate its efforts to strengthen the existing infrastructure with nutritional support and water supply and sanitation improvements. Its programme in Mali covered the Diré region, in one of the more directly affected areas, while a similarly comprehensive programme in Chad was based on the Mossoro hospital. The programme also included the training of national counterparts. In Somalia, long-term assistance was being complemented by emergency measures in nutrition and by measures to combat a recent epidemic. Similar assistance was being extended to Djibouti.

Italy had been giving emergency assistance to Ethiopia since November 1984. In the Makellé area it had built, equipped and was managing a camp for 30,000 refugees, and it had recently been successful in boring wells that would supply water to the refugees and the local population. Italy's total contribution to the emergency programme in the health sector alone had exceeded US$ 20 million over the past six months.

He shared WHO's view that emergency assistance could be of only limited value unless the efforts of all concerned were also aimed at developing longer-term plans and activities to tackle the problem at its roots and to strengthen the health services of the afflicted countries on a permanent basis. His country looked forward to developing closer understanding and cooperation with the Regional Director for Africa and his staff in those efforts.

Mr HILALE (Morocco) said that, true to its tradition of African solidarity, Morocco had always participated in the momentous events of African history. Having been in the vanguard of the struggle for African liberation, it was now bringing relief to fraternal African States stricken by drought, famine and epidemics. In that spirit, and despite its own economic difficulties and drought problems, his country had provided bilateral assistance to many Sahelian countries, particularly in the form of foodstuffs, drugs and well-boring equipment, and had donated US$ 10 million at the United Nations Conference on the Emergency Situation in Africa in March 1985. Accordingly, his delegation supported the draft resolution as amended and wished to become a co-sponsor.
He welcomed the Director-General's report and his efforts to associate WHO with the campaign of solidarity with the African countries stricken by drought and famine.

Mr QUTUB (Saudi Arabia) observed that, as shown in the Director-General's report, WHO's assistance to the drought-stricken and famine-affected countries in Africa had been provided in full collaboration with other international agencies. WHO had made noteworthy efforts. The drought in Africa was a major calamity that had taken many lives and given rise to an influx of refugees into other stricken areas, which had led to a further deterioration in their health, economic and social conditions. In a spirit of humanitarian solidarity and in keeping with the precepts of the Islamic faith, his country had been in the vanguard of assistance to stricken areas, where it had established relief centres. The deteriorating health situation resulting from the drought called for sustained emergency assistance in the field of health, nutrition, water supply, sanitation and housing as well as the necessary long-term measures to enable the affected countries to improve their economic and social conditions so that they could resume a normal productive life. His delegation therefore supported the draft resolution and amendments.

Mr NGUTA (Kenya) welcomed the Director-General's report and the action taken so far by WHO and expressed appreciation for assistance provided by Member States to the affected countries, whose health plans were likely to be compromised by the crisis. Since no early improvement in the situation could be foreseen, continued cooperation and assistance from Member States would be needed for any lasting solution.

The draft resolution before the Committee was designed to draw the international community's attention to the adverse effects of natural catastrophes and to enlist the necessary support to alleviate those effects in the short and medium term. His delegation wished to become a co-sponsor of the draft resolution, which it urged all Member States to support.

Mrs MEDEA (Burkina Faso), expressing appreciation for the Director-General's report, said that Burkina Faso was one of the countries belonging to the Inter-State Committee on Drought Control in the Sahel (CILSS) and housed its headquarters. It was very alive to the problems under discussion, since for over 10 years it had been suffering the effects of the chronic drought affecting the region. Despite their great courage, the people in the north of the country had become exhausted in their fight against adverse nature and had been forced to flee south with their cattle, nearly half of which had died on the long trek, while the remainder had lost so much of their carcass weight that they had had to be sold off at extremely low prices. Her country's National Revolutionary Council and Government had established a solidarity fund for the receipt of contributions, through which some, albeit inadequate, relief could be brought to the famine-stricken peoples. Assistance from the international community remained essential not only to solve the immediate problem of famine and its harmful consequences, particularly for health, but above all to facilitate a long-term solution in the sense of genuine and overall socioeconomic development.

Burkina Faso strongly supported the statements by the Secretary-General of the United Nations and the Director-General of WHO to the effect that emergency problems must not cause the basic development problems to be overlooked. Her delegation sincerely appreciated the already generous assistance provided by the international community and wholeheartedly supported and wished to co-sponsor the draft resolution before the Committee, as now amended.

Mr AKRAM (Pakistan) said that his delegation wished to be a co-sponsor of the draft resolution.

Mr KWEN Seung Yeun (Democratic People's Republic of Korea) welcomed the Director-General's report. His delegation shared WHO's concern for the drought-stricken and famine-affected countries in Africa and strongly supported the draft resolution as amended.

Dr JADAMBA (Mongolia) said that his country had consistently supported assistance to drought-stricken and famine-affected countries in Africa, which should be provided on a long-term basis and should be well directed and coordinated. He associated himself with the comments of previous speakers and supported the draft resolution as amended.

Dr MONEKOSO (Regional Director for Africa), responding to the question raised by the Egyptian delegate about the logistical problems that prevented help from reaching the affected populations, said that the difficulties caused by drought, famine and other disasters had imposed major managerial strains on the affected and transit countries, but that the political authorities of those countries were clearly not insensitive to the needs
of the affected populations. Reports from various sources, including UNDRO, had emphasized seaport constraints, insufficient road transport and difficult road conditions, but the teams which had been sent to the affected areas had made vigorous efforts to assist the countries in resolving those problems, helping them build bridges, organizing airlifts and furnishing trucks. WHO staff had been involved side-by-side with other agencies in those efforts. The situation illustrated the fact that emergency assistance should be accompanied by development cooperation, since it was the inadequacy of their infrastructure that hindered the affected countries in overcoming their difficulties.

The constraints which had been experienced in the internal distribution of food prevailed even under normal circumstances, not to mention during emergencies. The Regional Office for Africa had determined to strengthen its capacity to help the countries of the Region to deal more effectively with the health and nutritional aspects of emergencies, disaster preparedness and refugee relief, and had begun to develop a unit designed to deal specifically with that challenge.

He thanked all the countries that had expressed their solidarity with and provided concrete assistance to the peoples of Africa and assured them that, because of such continued development efforts, the time would soon come when African countries could join the international community in furnishing assistance in disaster situations.

Dr PARTOW (Assistant Director-General) expressed gratitude to delegates for their support for WHO's emergency relief policy and its efforts to date, and assured them that their comments would be taken into account. They had expressed unanimous concern for the problems being faced by drought-stricken and famine-affected African countries and had called on WHO to continue to provide assistance and to strengthen its role in improving health conditions. That approach reflected and emphasized the close link between emergency relief and development efforts mentioned in paragraph 5 of the Director-General's report. WHO was called upon to take the lead in disaster preparedness at the country level and to sharpen its technical and managerial capacity so that it could provide appropriate and timely support to the African countries affected by the crisis.

The Secretariat realized that it was facing a major challenge and that much needed to be done to improve its capacity to deal with emergency situations at all levels, especially at the country level. It would continue to work closely with other international organizations, nongovernmental organizations, and above all the Member States affected by the crisis.

The CHAIRMAN invited the Committee to consider the draft resolution and the amendments submitted by the delegate of Swaziland, which had received virtually unanimous support.

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 1983: Item 34.1 of the Agenda (Document A38/17)

Mr FURTH (Assistant Director-General), introducing the item, said that document A38/17, 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 most recent session. Full details could be found in the official records of the thirty-ninth session of the United Nations General Assembly, supplement No. 9 (A/39/9), 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 1983 and as reported by the Director-General in the document before the Committee.

Mr BOYER (United States of America) said that paragraphs 4, 5 and 6 of the document A38/17 described measures approved by the General Assembly to safeguard the provision of pension entitlements. There were questions in some quarters as to what the specialized agencies were doing to implement those measures, and he would welcome clarification on WHO's action in that regard.

1 Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA38.29.
Mr FURTH (Assistant Director-General) said that the Director-General was complying in full with the General Assembly's decisions. The Secretary of the Fund calculated the pensions which were due and requested the relevant organizations to make the necessary contributions; WHO did so on the basis of the revised scale of pensionable remuneration. The Director-General had established a suspense account equivalent to the difference between contributions calculated on the original and revised scales, an account which would finance any compensatory measures the General Assembly might approve for participants whose pensionable remuneration had been higher than the level established on 1 January 1985. If no such measures were approved, the funds would be returned to Member States in the form of casual income and to staff members at the end of the year.

Decision: The Committee decided to recommend to the Thirty-eighth 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 1983 and as reported by the Director-General.1

Appointment of representatives to the WHO Staff Pension Committee: Item 34.2 of the Agenda (Document A38/18)

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.

In 1976, the Executive Board had proposed a modification in the procedure for selecting Health Assembly representatives for the Pension Committee by providing that one member should be designated by name, to serve in a personal capacity, and should be appointed possibly for a term longer than the normal three years, whether or not he or she was or continued to be a member of the Board. Recognizing the importance of maintaining greater continuity of representation on the Pension Committee and on the United Nations Joint Staff Pension Board, the Health Assembly had accepted that recommendation and had in 1976, 1979 and 1982 appointed Dr A. Sauter to serve in a personal capacity, each time for three years. Dr Sauter's term of office, together with that of the alternate member designated by the Government of Pakistan, would expire at the closure of the current Health Assembly, and he had expressed the wish that his mandate not be renewed.

The Committee might therefore wish to recommend to the Health Assembly that it appoint its new representatives on the Pension Committee by designating as a member of the Committee for a given number of years a person who need not necessarily be a member of the Executive Board, selecting a Member State from among those entitled to designate a person to serve on the Executive Board, whose designated person would then be the alternate member of the Committee for a period of three years. As the Assembly's practice in the past had been to ensure that the WHO regions were equitably represented on the Pension Committee, it might wish to make its selection of the individual concerned and of the Member State from regions no longer represented on the Committee, in other words, from the European Region and the Eastern Mediterranean Region.

He called for nominations of a person who would serve on the Pension Committee in a personal capacity, replacing Dr Sauter.

Mrs OLLILA (Finland), seconded by Professor ROOS (Switzerland) and Mr BOYER (United States of America), nominated Dr J. J. A. Reid.

The CHAIRMAN called for nominations of a Member State entitled to designate a person on the Executive Board whose designee would be appointed alternate member of the Pension Committee to replace the member of the Executive Board designated by the Government of Pakistan.

Dr MARKIDES (Cyprus), seconded by Mr AKRAM (Pakistan), nominated Democratic Yemen.

Decision: The Committee decided to recommend to the Thirty-eighth World Health Assembly that Dr J. J. A. Reid should be appointed, in a personal capacity, as member of the WHO Staff Pension Committee and the member of the Executive Board designated by the

1 Transmitted to the Health Assembly in the Committee's fourth report and adopted as decision WHA38(11).
Government of Democratic Yemen as alternate member of the Committee, the appointments being for a period of three years.1

Dr REID (United Kingdom of Great Britain and Northern Ireland) said that he would be honoured to succeed Dr Sauter in the position for which he had just been nominated and was sure that the Committee would endorse the idea of sending a message of gratitude to Dr Sauter for the services he had rendered.

Mr OBADI (Democratic Yemen) thanked the Committee for the confidence it had placed in his country, which reflected its understanding of Democratic Yemen's interest in WHO and its programmes.

3. FOURTH REPORT OF COMMITTEE B (Document A38/36)

Dr JAKAB (Hungary), Rapporteur, read out the draft fourth report of Committee B.

The report was adopted (see document WHA38/1985/REC/2).

4. CLOSURE

The CHAIRMAN thanked all concerned for their assistance and cooperation and declared the work of the Committee completed.

The meeting rose at 17h15.

1 Transmitted to the Health Assembly in the Committee's fourth report and adopted as decision WHA38(12).
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