WHA32/1979/REC/1

WORLD HEALTH ORGANIZATION

THIRTY-SECOND WORLD HEALTH ASSEMBLY

GENEVA, 7-25 MAY 1979

RESOLUTIONS AND DECISIONS
ANNEXES

GENEVA
1979

ABBREVIATIONS

The following abbreviations are used in WHO documentation:

ACABQ - Advisory Committee on Administrative and Budgetary Questions
ACAST - Advisory Committee on the Application of Science and Technology to Development
ACC - Administrative Committee on Coordination
CIDA - Canadian International Development Agency
CIOMS - Council for International Organizations of Medical Sciences
DANIDA - Danish International Development Agency
ECA - Economic Commission for Africa
ECE - Economic Commission for Europe
ECLA - Economic Commission for Latin America
ECWA - Economic Commission for Western Asia
ESCAP - Economic and Social Commission for Asia and the Pacific
FAO - Food and Agriculture Organization of the United Nations
IAEA - International Atomic Energy Agency
IARC - International Agency for Research on Cancer
IBRD - International Bank for Recontruction and Development
ICAO - International Civil Aviation Organization
ILO - International Labour Organisation (Office)
IMCO - Inter-Governmental Maritime Consultative Organization
ITU - International Telecommunication Union
NORAD - Norwegian Agency for International Development
OAU - Organization of African Unity
OECD - Organisation for Economic Co-operation and Development
PAHO - Pan American Health Organization
PASB - Pan American Sanitary Bureau
SIDA - Swedish International Development Authority
UNCTAD - United Nations Conference on Trade and Development
UNDP - United Nations Development Programme
UNDRO - Office of the United Nations Disaster Relief Coordinator
UNEP - United Nations Environment Programme
UNESCO - United Nations Educational, Scientific and Cultural Organization
UNFDAC - United Nations Fund for Drug Abuse Control
UNFPA - United Nations Fund for Population Activities
UNHCR - Office of the United Nations High Commissioner for Refugees
UNICEF - United Nations Children's Fund
UNIDO - United Nations Industrial Development Organization
UNITAR - United Nations Institute for Training and Research
UNRWA - United Nations Relief and Works Agency for Palestine Refugees in the Near East
UNSCEAR - United Nations Scientific Committee on the effects of Atomic Radiation
USAID - United States Agency for International Development
WFP - World Food Programme
WHO - World Health Organization
WIPO - World Intellectual Property Organization
WMO - World Meteorological Organization

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

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MEMBERSHIP OF THE HEALTH ASSEMBLY

PREFACE

The Thirty-second World Health Assembly was held at the Palais des Nations, Geneva, from 7 to 25 May 1979, in accordance with the decision of the Executive Board at its sixty-second session. Its proceedings are published in three volumes, containing, in addition to other relevant material:

Resolutions and decisions,[1] and list of participants - document WHA32/1979/REC/1

Verbatim records of plenary meetings, and committee reports - document WHA32/1979/REC/2

Summary records of committees - document WHA32/1979/REC/3

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[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 1978. 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).

RESOLUTIONS

WHA32.1 Financial report on the accounts of WHO for 1978, and report of the External Auditor

The Thirty-second World Health Assembly,

Having examined the financial report of the Director-General for the period 1 January to 31 December 1978 and the report of the External Auditor for the same financial period;

Having noted the report of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-second World Health Assembly;

ACCEPTS the Director-General's financial report and the report of the External Auditor for the financial year 1978.

Hbk Res., Vol. II (3rd ed.), 7.1.11

(Ninth plenary meeting, 16 May 1979 - Committee B, first report)

WHA32.2 Status of collection of annual contributions and of advances to the Working Capital Fund

The Thirty-second World Health Assembly

1. NOTES the status, as at 14 May 1979, of the collection of annual contributions and of advances to the Working Capital Fund, as reported by the Director-General;

2. CALLS THE ATTENTION of Members to the importance of paying their annual contributions as early as possible in the Organization's financial year, in order that the approved annual programme can be carried out as planned;

3. URGES Members in arrears to make special efforts to liquidate their arrears during 1979;

4. REQUESTS the Director-General to communicate this resolution to Members in arrears and to draw their attention to the fact that continued delay in payment could have serious financial implications for the Organization.

Hbk Res., Vol. II (3rd ed.), 7.1.2.4

(Ninth plenary meeting, 16 May 1979 - Committee B, first report)

WHA32.3 Supplementary budgetary requirements for 1979

The Thirty-second World Health Assembly,

Having considered the proposals of the Director-General and the recommendations of the Executive Board concerning supplementary budgetary requirements for 1979 to meet the unforeseen additional costs of implementing the approved programme budget for 1979 as a consequence of currency fluctuations;[1]

Considering it important not to increase Members' contributions for the year 1979 for this purpose;

Recalling resolution WHA31.7, the terms of which in so far as they relate to the financial year 1979 are superseded by the present resolution;

1. AUTHORIZES the Director-General, notwithstanding the provisions of Financial Regulation 4.1 and the terms of the Appropriation Resolution for the financial year 1979,[2] to charge against available casual income the net additional costs to the Organization under the regular programme budget resulting from differences between the WHO budgetary rate of exchange and the United Nations/WHO accounting rates of exchange with respect to the US dollar/Swiss franc relationship prevailing during that financial year, provided that such charges against casual income shall not exceed US $15 000 000 in 1979;

2. REQUESTS the Director-General, notwithstanding the provisions of Financial Regulation 4.1 and the terms of the Appropriation Resolution for the financial year 1979, to transfer to casual income the net savings under the regular programme budget resulting from differences between the WHO budgetary rate of exchange and the United Nations/WHO accounting rates of exchange with respect to the US dollar/Swiss franc relationship prevailing during that financial year, provided that, having regard to inflationary trends and other factors which may affect the implementation of the regular programme budget, such transfers to casual income need not exceed US $15 000 000 in 1979;

3. FURTHER REQUESTS the Director-General to report such charges or transfers in the financial report for 1979.

Hbk Res., Vol. II (3rd ed.), 2.3.8; 7.1.4

(Ninth plenary meeting, 16 May 1979 - Committee B, first report)

WHA32.4 Report on casual income

The Thirty-second World Health Assembly,

Having considered the recommendation of the Executive Board on the use of casual income to reduce adverse effects of currency fluctuations on the programme budget for the financial period 1980-1981;[3]

1. AUTHORIZES the Director-General, notwithstanding the provisions of Financial Regulation 4.1 and the terms of the Appropriation Resolution for the financial period 1980-1981, to charge against available casual income the net additional costs to the Organization under the regular programme budget resulting from differences between the WHO budgetary rate of exchange and the United Nations/WHO accounting rates of exchange with respect to the US dollar/Swiss franc relationship prevailing during this financial period, provided that such charges against casual income shall not exceed US $15 000 000 in 1980-1981;

[1] Resolution EB63.R1.

[2] Resolution WHA31.22.

[3] Resolution EB63.R7.

2. REQUESTS the Director-General, notwithstanding the provisions of Financial Regulation 4.1 and the terms of the Appropriation Resolution for the financial period 1980-1981, to transfer to casual income the net savings under the regular programme budget resulting from differences between the WHO budgetary rate of exchange and the United Nations/WHO accounting rates of exchange with respect to the US dollar/Swiss franc relationship prevailing during this financial period, provided that, having regard to inflationary trends and other factors which may affect the implementation of the regular programme budget, such transfers to casual income need not exceed US $15 000 000 in 1980-1981;

3. FURTHER REQUESTS the Director-General to report such charges or transfers in the financial report for the financial period 1980-1981;

4. STRESSES the importance of Members' paying their contributions to the Organization's budget in accordance with Financial Regulations 5.3 and 5.6, that is, not later than the first day of the year to which they relate, in order that the approved programme may be carried out as planned;

5. CALLS THE ATTENTION of Members to the fact that the Organization's ability to earn casual income depends largely upon the timely payment by Members of their assessed contributions to the approved budget, and that the earnings of such income could be significantly increased if Members were to pay their entire contribution to a given biennial budget prior to or at the beginning of the financial period concerned rather than in two equal annual instalments.

Hbk Res., Vol. II (3rd ed.), 2.3.9; 7.1.4

(Ninth plenary meeting, 16 May 1979 - Committee B, first report)

WHA32.5 Use of the Portuguese language at the Regional Office for Africa

The Thirty-second World Health Assembly,

Having considered the report of the Director-General on the use of the Portuguese language at the Regional Office for Africa, presenting a plan for the phased introduction of that language at the Regional Office, and the recommendation of the Executive Board thereon;[1]

1. ENDORSES the adoption of the Portuguese language as the third working language of the Regional Committee for Africa;

2. APPROVES the plan presented by the Director-General for the phased introduction of the Portuguese language at the Regional Office for Africa.

Hbk Res., Vol. II (3rd ed.), 5.2.1

(Eleventh plenary meeting, 18 May 1979 - Committee B, second report)

[1] Document EB63/48, resolution EB63.R6 and Annex 3.

WHA32.6 Assessment of Djibouti

The Thirty-second World Health Assembly,

Recalling that the Thirty-first World Health Assembly, in resolution WHA31.14, fixed a provisional assessment for Djibouti, to be adjusted to the definitive assessment rate when established;

Noting that the United Nations General Assembly, in resolution 33/11, established the assessment of Djibouti at the rates of 0.02% for 1977 and 0.01% for 1978 and 1979;

Recalling the principle established in resolution WHA8.5, and confirmed in resolution WHA24.12, that the latest available United Nations scale of assessment should be used as a basis for determining the scale of assessment to be used by WHO;

Recalling further that the Twenty-sixth World Health Assembly, in resolution WHA26.21, affirmed its belief that the scale of assessment in WHO should follow as closely as possible that of the United Nations;

DECIDES that Djibouti shall be assessed at the rate of 0.02% for 1978 and at the rate of 0.01% for 1979 and future years.

Hbk Res., Vol. II (3rd ed.), 7.1.2.2

(Eleventh plenary meeting, 18 May 1979 - Committee B, second report)

WHA32.7 Assessment of Viet Nam

The Thirty-second World Health Assembly,

Recalling that the Thirtieth World Health Assembly, in resolution WHA30.13, fixed a provisional assessment for Viet Nam, to be adjusted to the definitive assessment rate when established;

Noting that the United Nations General Assembly, in resolution 33/11, established the assessment of Viet Nam at the rates of one-half of 0.02% for the second half of 1976 and 0.03% for 1977 and for 1978 and 1979;

Recalling the principle established in resolution WHA8.5, and confirmed in resolution WHA24.12, that the latest available United Nations scale of assessment should be used as a basis for determining the scale of assessment to be used by WHO;

Recalling further that the Twenty-sixth World Health Assembly, in resolution WHA26.21, affirmed its belief that the scale of assessment in WHO should follow as closely as possible that of the United Nations;

DECIDES:

(1) that Viet Nam shall be assessed at the rate of one-half of 0.02% for 1976 from 1 July 1976 onwards;

(2) that Viet Nam shall be assessed at the rate of 0.03% for 1977 and future years.

Hbk Res., Vol. II (3rd ed.), 7.1.2.2

(Eleventh plenary meeting, 18 May 1979 - Committee B, second report)

WHA32.8 Scale of assessment for the financial period 1980-1981

The Thirty-second World Health Assembly

1. DECIDES that the scale of assessment for 1980-1981 shall, subject to the provisions of paragraph 2 below, be as follows:

Member	Scale (percentage)
Afghanistan	0.01
Albania	0.01
Algeria	0.10
Angola	0.02
Argentina	0.83
Australia	1.51
Austria	0.63
Bahamas	0.01
Bahrain	0.01
Bangladesh	0.04
Barbados	0.01
Belgium	1.06
Benin	0.01
Bolivia	0.01
Botswana	0.01
Brazil	1.02
Bulgaria	0.14
Burma	0.01
Burundi	0.01
Byelorussian Soviet Socialist Republic	0.40
Canada	2.99
Cape Verde	0.01
Central African Empire	0.01
Chad	0.01
Chile	0.09
China	5.41
Colombia	0.11
Comoros	0.01
Congo	0.01
Costa Rica	0.02
Cuba	0.11
Cyprus	0.01
Czechoslovakia	0.83
Democratic Kampuchea	0.01
Democratic People's Republic of Korea	0.05
Democratic Yemen	0.01
Denmark	0.63
Djibouti	0.01
Dominican Republic	0.02
Ecuador	0.02
Egypt	0.08
El Salvador	0.01
Ethiopia	0.01
Fiji	0.01
Finland	0.43
France	5.73
Gabon	0.01
Gambia	0.01
German Democratic Republic	1.31
Germany, Federal Republic of	7.58
Ghana	0.02
Greece	0.34

Member	Scale (percentage)
Grenada	0.01
Guatemala	0.02
Guinea	0.01
Guinea-Bissau	0.01
Guyana	0.01
Haiti	0.01
Honduras	0.01
Hungary	0.32
Iceland	0.02
India	0.67
Indonesia	0.14
Iran	0.39
Iraq	0.08
Ireland	0.15
Israel	0.23
Italy	3.32
Ivory Coast	0.02
Jamaica	0.02
Japan	8.50
Jordan	0.01
Kenya	0.01
Kuwait	0.15
Lao People's Democratic Republic	0.01
Lebanon	0.03
Lesotho	0.01
Liberia	0.01
Libyan Arab Jamahiriya	0.16
Luxembourg	0.04
Madagascar	0.01
Malawi	0.01
Malaysia	0.09
Maldives	0.01
Mali	0.01
Malta	0.01
Mauritania	0.01
Mauritius	0.01
Mexico	0.78
Monaco	0.01
Mongolia	0.01
Morocco	0.05
Mozambique	0.02
Namibia	0.01
Nepal	0.01
Netherlands	1.40
New Zealand	0.25
Nicaragua	0.01
Niger	0.01
Nigeria	0.13
Norway	0.44
Oman	0.01
Pakistan	0.07
Panama	0.02
Papua New Guinea	0.01
Paraguay	0.01
Peru	0.06
Philippines	0.10
Poland	1.37
Portugal	0.19
Qatar	0.02

Member	Scale (percentage)
Republic of Korea	0.13
Romania	0.23
Rwanda	0.01
Samoa	0.01
Sao Tome and Principe	0.01
Saudi Arabia	0.23
Senegal	0.01
Sierra Leone	0.01
Singapore	0.08
Somalia	0.01
South Africa	0.41
Southern Rhodesia	0.01
Spain	1.51
Sri Lanka	0.02
Sudan	0.01
Suriname	0.01
Swaziland	0.01
Sweden	1.22
Switzerland	0.94
Syrian Arab Republic	0.02
Thailand	0.10
Togo	0.01
Tonga	0.01
Trinidad and Tobago	0.03
Tunisia	0.02
Turkey	0.29
Uganda	0.01
Ukrainian Soviet Socialist Republic	1.51
Union of Soviet Socialist Republics	11.42
United Arab Emirates	0.07
United Kingdom of Great Britain and Northern Ireland	4.45
United Republic of Cameroon	0.01
United Republic of Tanzania	0.01
United States of America	25.00
Upper Volta	0.01
Uruguay	0.04
Venezuela	0.38
Viet Nam	0.03
Yemen	0.01
Yugoslavia	0.38
Zaire	0.02
Zambia	0.02

2. REQUESTS the Director-General, in the event that assessments are fixed provisionally or definitively by the present Health Assembly for any new Members, to adjust the scale as set forth in paragraph 1.

Hbk Res., Vol. II (3rd ed.), 7.1.2.1

(Eleventh plenary meeting, 18 May 1979 - Committee B, second report)

WHA32.9 Appointment of External Auditor

The Thirty-second World Health Assembly

1. RESOLVES that Sir Douglas Henley be appointed External Auditor of the accounts of the World Health Organization for the financial period 1980-1981 and that he conduct his audits in accordance with the principles incorporated in Article XII of the Financial Regulations, with the provision that, should the necessity arise, he may designate a representative to act in his absence;

2. EXPRESSES its thanks to Sir Douglas Henley for the work he has performed for the Organization in his audit of the accounts for the financial year 1978.

Hbk Res., Vol. II (3rd ed.), 7.1.11.1

(Eleventh plenary meeting, 18 May 1979 - Committee B, second report)

WHA32.10 Review of the Working Capital Fund

The Thirty-second World Health Assembly,

Having considered the recommendations of the Executive Board on the Working Capital Fund;[1]

A

1. DECIDES that:

(1) Part I of the Working Capital Fund, composed of advances assessed on Members and Associate Members, shall be established in the amount of US $5 126 130, to which shall be added the assessments of any Members or Associate Members joining the Organization after 30 September 1978;

(2) the advances to the Working Capital Fund shall be assessed on the basis of the scale of assessment adopted by the Thirty-second World Health Assembly for the financial period 1980-1981, adjusted to the nearest US $10;

(3) any additional advances shall be due and payable on 1 January 1980;

(4) any credits due to Members and Associate Members shall be refunded on 1 January 1980 by applying these credits to any contributions outstanding on that date or to the 1980 assessments;

2. REQUESTS the Members and Associate Members concerned to provide in their national budgets for payment of the additional advances on the due date;

B

1. DECIDES that Part II of the Working Capital Fund shall remain established at US $6 000 000;

2. DECIDES also that Part II of the Working Capital Fund shall continue to be financed by appropriations by the Health Assembly from casual income as recommended by the Executive Board after considering the report of the Director-General; such appropriations shall be voted separately from the appropriations for the relevant financial period;

[1] Resolution EB63.R23.

C

1. AUTHORIZES the Director-General to advance from the Working Capital Fund:

(1) such funds as may be required to finance the appropriations pending receipt of contributions from Members and Associate Members; sums so advanced shall be reimbursed to the Working Capital Fund as contributions become available;

(2) such sums as may be required during a calendar year to meet unforeseen or extraordinary expenses, and to increase the relevant appropriation sections accordingly, provided that not more than US $250 000 is used for such purposes, except that with the prior concurrence of the Executive Board a total of US $2 000 000 may be used;

(3) such sums as may be required for the provision of emergency supplies to Members and Associate Members on a reimbursable basis; sums so advanced shall be reimbursed to the Working Capital Fund when payments are received, provided that the total amount so withdrawn shall not exceed US $200 000 at any one time, and provided further that the credit extended to any one Member or Associate Member shall not exceed US $50 000 at any one time;

2. REQUESTS the Director-General to report annually to the Health Assembly:

(1) all advances made under the authority vested in him to meet unforeseen or extraordinary expenses and the circumstances relating thereto, and to make provision in the estimates for the reimbursement of the Working Capital Fund, except when such advances are recoverable from other sources;

(2) all advances made under the authority of paragraph C.1(3) for the provision of emergency supplies to Members and Associate Members, together with the status of reimbursement by those concerned;

D

REQUESTS the Director-General to continue his efforts to secure early payment of Members' and Associate Members' assessed contributions, in order to preclude the necessity of increasing the amount of the Working Capital Fund;

E

REQUESTS the Director-General to submit a report on the Working Capital Fund to the Executive Board and the Health Assembly when he considers it warranted, and in any case not less frequently than every third year.

Hbk Res., Vol. II (3rd ed.), 7.1.3

(Eleventh plenary meeting, 18 May 1979 - Committee B, second report)

WHA32.11 United Nations Water Conference: Follow-up to the Mar del Plata Action Plan

The Thirty-second World Health Assembly,

Recalling resolutions WHA30.33 and WHA31.40, and having considered resolution EB63.R32 of the Executive Board;

Reiterating that safe drinking-water and sanitation are essential components of primary health care;

Recognizing the importance of the targets set at Mar del Plata for the International Drinking-Water Supply and Sanitation Decade for attaining a satisfactory level of health;

1. THANKS the Director-General for his report and endorses the action he has taken, as outlined therein;

2. URGES Member States:

(1) to give high priority to the provision of safe water supply and sanitation in national development plans, bearing in mind that these services are essential for the attainment of the goal of health for all by the year 2000;

(2) to give urgent attention to preparing national plans and programmes for the Decade if they have not yet done so;

(3) to support the cooperative action for the Decade initiated by the United Nations, the United Nations Children's Fund, the United Nations Development Programme, the International Labour Organisation, the Food and Agriculture Organization of the United Nations, the World Health Organization, and the World Bank;

(4) to support the UNDP resident representative by establishing a mechanism within the government that will assure the effective and coordinated interaction of external agencies and all relevant government bodies;

3. REQUESTS the Director-General:

(1) to continue to implement resolutions WHA30.33 and WHA31.40;

(2) to ensure the full coordination of WHO's activities in this field with other efforts of the Organization for providing primary health care and attaining the social goal of health for all by the year 2000;

4. EXPRESSES its thanks to those governments that have made contributions to WHO, and to the United Nations Development Programme for its support to the Organization's preparatory action at country level, particularly in the least developed countries;

5. CALLS UPON other Member States also to support these activities.

Hbk Res., Vol. II (3rd ed.), 1.12.2.1

(Eleventh plenary meeting, 18 May 1979 - Committee B, second report)

WHA32.12 Members in arrears in the payment of their contributions to an extent which may invoke Article 7 of the Constitution: Amendment to Rule 72 of the Rules of Procedure of the World Health Assembly

The Thirty-second World Health Assembly,

Having regard to Rule 72 of the Rules of Procedure of the World Health Assembly;

Noting that any application of Article 7 of the Constitution of the Organization necessarily has exceptionally important consequences for the Member affected and for the Organization;

DECIDES, pursuant to Rule 121 of the Rules of Procedure, to amend Rule 72 as follows:

Strike out "and" before "decisions"; change the period after "budget" to a semicolon; and add at the end of the paragraph: "and decisions to suspend the voting privileges and services of a Member under Article 7 of the Constitution". The result is that Rule 72 as amended would read as follows (new text underlined):

Rule 72

Decisions by the Health Assembly on important questions shall be made by a two-thirds majority of the Members present and voting. These questions shall include: the adoption of conventions or agreements; the approval of agreements bringing the Organization into relation with the United Nations and with intergovernmental organizations and agencies in accordance with Articles 69, 70 and 72 of the Constitution; amendments to the Constitution; decisions on the amount of the effective working budget; and decisions to suspend the voting privileges and services of a Member under Article 7 of the Constitution.

Hbk Res., Vol. II (3rd ed.), 6.2.5; 4.1.2

(Twelfth plenary meeting, 22 May 1979 - Committee B, third report)

WHA32.13 Development of the mental health programme

The Thirty-second World Health Assembly,

Recalling resolutions WHA28.84, WHA29.21 and WHA30.45, which note with concern the magnitude and severity of psychosocial stresses and their effects on the health of populations, as well as the importance of psychosocial factors in health and health care;

Recalling that the International Conference on Primary Health Care, held in Alma-Ata, recommended that primary health care should include as one of its elements the promotion of mental health, linking mental health with the training of primary care personnel, provision of health services and sharing of research;

Considering that, in planning for health for all by the year 2000 and in implementing such plans, due emphasis needs to be given to the promotion of mental health and psychosocial development, including identification of research in both areas;

Noting that the response of Member States in providing voluntary contributions to the mental health programme has been insufficient to provide the financial and technical means necessary for the full implementation of the resolutions referred to above;

1. THANKS those governments, foundations, industries, labour organizations and nongovernmental organizations which have made contributions to the programme, thus allowing for priority activities to be initiated;

2. URGES Member States which have not yet contributed to this programme to make every effort to do so;

3. INVITES foundations, industry, labour organizations, nongovernmental organizations and individuals to support WHO in its efforts to lay emphasis on the development of the mental health programme;

4. DECIDES to establish a Special Account for the Mental Health Programme as a subaccount of the Voluntary Fund for Health Promotion;

5. REQUESTS the Director-General to submit a report to a future Health Assembly on further developments in regard to this programme and the support received for it.

Hbk Res., Vol. II (3rd ed.), 1.8; 7.1.10.1 (Twelfth plenary meeting, 22 May 1979 - Committee A, first report)

WHA32.14 Workers' health programme

The Thirty-second World Health Assembly,

Having considered the progress report of the Director-General on the occupational health programme;

Noting with concern the serious increase in occupational and work-related diseases in many parts of the world where, at the same time, occupational health services are either nonexistent, weak, or isolated from general health services;

Noting further that the health of the worker is a major factor in the wellbeing of the family and community and has a considerable impact on human productivity and socioeconomic development;

Convinced that the field of occupational health calls for a broad multidisciplinary approach;

Recalling that the Declaration of Alma-Ata refers to bringing health care as close as possible to where people live and work, and convinced that this will require the use of resources in industry and other economic activities to enhance health promotion;

Aware of the opportunities that work has in health promotion and that these have not as yet been fully exploited for the improvement of the health of nations;

Concerned at the uncontrolled introduction of some industrial and agricultural processes with physical, chemical, biological and psychosocial hazards, especially in developing countries where lower standards of health may further aggravate the situation;

Stressing that in many countries enterprises and employers do not provide adequate resources and facilities for the development of occupational health services, while there is inadequate legislation in this field;

Aware that the health and wellbeing of the families of workers have a profound influence on the health of workers;

Noting that migrant workers have particular health and social problems, as do their families, both in the countries of employment and in their countries of origin;

Noting that the progress report of the Director-General contains important elements and proposes new programme areas requiring action by WHO, as well as coordination within WHO and with the International Labour Organisation and other United Nations agencies and organizations;

Noting also that technology and standards in occupational health are in need of coordination and adaptation to conditions in developing countries, and that the rapid increase of toxic agents and biological hazards in work-places and of occupational hazards require more intensive efforts by WHO and countries;

1. THANKS the Director-General for his progress report and efforts in developing this programme;

2. CONFIRMS its conviction that workers' health is an essential programme in which WHO should maintain its leading role;

3. REITERATES those recommendations and requests addressed to Member States and to the Director-General in resolution WHA29.57 and other related resolutions;

4. URGES Member States:

(1) to give special attention to working people by developing appropriate occupational health care in work-places as a contribution to the attainment of health for all by the year 2000;

(2) to develop legislation aimed at increasing the provision of resources by enterprises and employers for such occupational health care, and at meeting the special health and related social needs of migrant workers and their families;

(3) to strengthen coordination between health care services for workers, where they exist, and general health services;

(4) to develop and strengthen occupational health institutions and to provide measures for preventing hazards in work-places, for the setting of standards and for research and training in occupational health;

5. REQUESTS the Director-General:

(1) to prepare a programme of action to deal with the new dimension contained in his progress report, and to present a further progress report to the Thirty-third World Health Assembly;

(2) to strengthen WHO's occupational health resources so as to activate more effective technical cooperation with Member States and to collaborate in setting occupational health standards and guidelines;

(3) to initiate appropriate mechanisms for seeking extrabudgetary resources and voluntary contributions to implement and strengthen the workers' health programme and to report thereon to a future Health Assembly;

(4) to strengthen cooperation and collaboration, in respect of WHO's workers' health programme, with the International Labour Organisation and other organizations of the United Nations system, such as the United Nations Environment Programme and the United Nations Industrial Development Organization, as well as other organizations, and to report thereon to the Thirty-third World Health Assembly.

Hbk Res., Vol. II (3rd ed.), 1.6.3

(Twelfth plenary meeting, 22 May 1979 - Committee A, first report)

WHA32.15 Development and coordination of biomedical and health services research

The Thirty-second World Health Assembly,

Recalling resolutions WHA25.60, WHA27.61, WHA28.70, WHA29.64, WHA30.40 and WHA31.35, as well as the Executive Board's decision at its sixty-third session in January 1979 concurring with the conclusions of its Programme Committee on the review of biomedical and health services research;[1]

Considering that biomedical and health services research and application of its results will be among the decisive factors for the attainment of the goal of health for all by the year 2000;

Noting:

(a) the progress made in strengthening national and regional research capabilities and in establishing research coordination mechanisms at regional and global levels;

(b) that WHO's research priorities are now being defined in accordance with the policy directives of the governing bodies by groups of national scientists, e.g. the global and regional Advisory Committees on Medical Research, and other mechanisms;

(c) that the Director-General is preparing a report on the research activities of the Organization, including their management;

(d) that major portions of the Organization's regular budget for research are invested in research in, or for the benefit of, developing countries;

1. URGES Member States:

(1) to identify and pursue, in collaboration with WHO as appropriate, research that is most relevant to their own major health problems, and establish effective focal points for national coordination of such research;

(2) to intensify technical cooperation among themselves for their mutual benefit in matters of biomedical and health services research of common interest;

(3) to make even greater use of WHO's research development and promotion initiatives and its regional and global research coordination mechanisms;

(4) to facilitate a continuing expansion of the participation and collaboration of national experts and institutions in WHO-coordinated research activities;

2. CALLS UPON Member States and bilateral, multilateral and voluntary agencies to support these initiatives by making contributions to WHO-coordinated research as an important part of the strategies for attaining health for all by the year 2000;

3. REQUESTS the Director-General to accelerate the further development and application of activities which will:

(1) enhance national research capability through institutional strengthening and training of national scientists, including the important area of health services research;

(2) support national research centres in developing methodologies for conducting health services research and in establishing principles and methods for research management, including planning, programming, coordination, evaluation and practical application;

[1] See documents EB63/48, p. 40, and EB63/49, p. 90.

(3) maximize the utilization of national research centres, particularly in developing countries, for collaborative research activities with WHO, in order to guarantee a just geographical distribution of collaborating centres and cooperating experts;

(4) facilitate collaborative research on health problems which transcend national and regional boundaries;

(5) result in the finalization of a comprehensive medium-term programme with respect to the Organization's research promotion and development efforts;

(6) strengthen the coordinating role of the global Advisory Committee on Medical Research and its administrative support;

(7) ensure that research-related policies of the regional committees, Executive Board and Health Assembly are effectively translated into national, regional and global research strategies for the attainment of health for all by the year 2000;

4. FURTHER REQUESTS the Director-General to ensure the active participation of WHO in the United Nations Conference on Science and Technology for Development to be held in Vienna in 1979 in order to ensure the inclusion of health in priorities for scientific and technological development.

Hbk Res., Vol. II (3rd ed.), 1.5

(Twelfth plenary meeting, 22 May 1979 - Committee A, first report)

WHA32.16 Health laboratory technology

The Thirty-second World Health Assembly,

Recalling the International Conference on Primary Health Care held in Alma-Ata in 1978;

Recalling resolution WHA29.74, on promotion of health technology for rural development and primary health care, resolutions WHA27.51, WHA27.58, WHA28.58, WHA31.44 and others, as well as the section on prevention and control of communicable diseases in the Sixth General Programme of Work, all of which require health laboratory support for their effective implementation;

Emphasizing the need for an integrated health laboratory service;

Bearing in mind the low priority given to health laboratory services in many countries and their frequent underdevelopment in relation to other components of national health services, and the fact that laboratory workers with basic training and equipment could provide the minimal clinical and public health service required;

1. URGES Member States which have not already done so to give due consideration to the development of health laboratory services;

2. REQUESTS the Director-General:

(1) to intensify technical cooperation with and among Member States for the establishment and development of simple laboratory services for clinical and public health purposes to assist in the clinical management, control and prevention of diseases, and to include the monitoring of environmental hazards, particularly in water;

(2) to develop appropriate technology for the use of health laboratories in developing countries, particularly in support of primary health care;

(3) to intensify the dialogue with the manufacturers of laboratory equipment and reagents for this purpose, in order to make these available at low price and guaranteed quality to the countries in need;

(4) to reflect more adequately the importance of health laboratory services in the programme budget of WHO.

Hbk Res., Vol. II (3rd ed.), 1.6.2.1

(Twelfth plenary meeting, 22 May 1979 - Committee A, first report)

WHA32.17 Members in arrears in the payment of their contributions to an extent which may invoke Article 7 of the Constitution

The Thirty-second World Health Assembly,

Having considered the report of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-second World Health Assembly on Members in arrears in the payment of their contributions to an extent which may invoke the provisions of Article 7 of the Constitution;

Having noted that Chad and the Dominican Republic are in arrears to such an extent that it is necessary for the Assembly to consider, in accordance with Article 7 of the Constitution, whether or not the voting privileges of these Members should be suspended;

Noting the payment now being made by the Dominican Republic;

Noting further that a payment was made by Chad in 1978;

Recognizing the efforts made by those two countries to liquidate their arrears;

1. DECIDES not to suspend the voting privileges of Chad and the Dominican Republic at the Thirty-second World Health Assembly;

2. URGES these two Members to intensify their efforts to achieve regularization of their position at the earliest possible date;

3. REQUESTS the Director-General to communicate this resolution to the Members concerned.

Hbk Res., Vol. II (3rd ed.), 7.1.2.4

(Twelfth plenary meeting, 22 May 1979 - Committee B, fourth report)

WHA32.18 Health assistance to refugees and displaced persons in Cyprus

The Thirty-second 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 and WHA31.25;

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-third World Health Assembly on such assistance.

Hbk Res., Vol. II (3rd ed.), 8.1.4.4

(Twelfth plenary meeting, 22 May 1979 - Committee B, fourth report)

WHA32.19 Health and medical assistance to Lebanon

The Thirty-second World Health Assembly,

Mindful of the principle that the health of all peoples is basic to the maintenance of peace and security;

Recalling resolutions WHA29.40, WHA30.27 and WHA31.26;

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

Considering that the continuing health problems in Lebanon call for further assistance;

1. NOTES with satisfaction the information supplied by the Director-General regarding the health and medical assistance already provided, and thanks him for his efforts;

2. EXPRESSES its thanks to all the organizations that have helped WHO to attain its objectives in this field;

3. REQUESTS the Director-General to continue and intensify the health and medical assistance to Lebanon, allocating for this purpose, and to the extent possible, funds from the regular budget and other financial resources, and to report to the Thirty-third World Health Assembly.

Hbk Res., Vol. II (3rd ed.), 1.4.3

(Twelfth plenary meeting, 22 May 1979 - Committee B, fourth report)

WHA32.20 Cooperation with newly independent and emerging States in Africa: Liberation struggle in Southern Africa - I

The Thirty-second World Health Assembly,

Recalling the provisions of resolutions WHA29.23, WHA30.24 and WHA31.52;

Considering the escalation and intensification of acts of aggression against the People's Republic of Angola, the People's Republic of Mozambique and the Republic of Zambia and the bombing of their civilian populations by the illegal regime of Southern Rhodesia and the racist regime of South Africa, as well as the armed aggressions, provocations and measures of economic blackmail against the sovereignty of Botswana and Lesotho;

Considering also that the so-called "internal settlement" in Zimbabwe and Namibia constitutes another threat to the security and welfare of the peoples of Angola, Mozambique and Zambia;

Considering further that the policy of the illegal regime of Southern Rhodesia and the racist regime of South Africa has led to a considerable increase in the number of refugees in Angola, Botswana, Lesotho, Mozambique and Zambia, forcing them to live under sanitary conditions conducive to the outbreak of epidemics;

Noting that these host countries do not have the necessary means to ensure the minimum sanitary conditions for survival and for the protection of these refugees' health;

Noting, further, the sacrifices made by the host countries in trying to meet the minimum hygienic and health conditions necessary for the protection of the moral and physical health of the refugees;

1. REITERATES its satisfaction with the concerted efforts made by the Office of the United Nations High Commissioner for Refugees, the United Nations Development Programme, the Office of the United Nations Disaster Relief Coordinator, the United Nations Children's Fund, the International Committee of the Red Cross, the League of Red Cross Societies, and WHO to engage in technical cooperation with the Member States concerned;

2. GIVES its full support to the front-line States and to Lesotho and Swaziland for the efforts undertaken on behalf of refugees from countries under the domination of illegal or racist regimes;

3. REQUESTS the Director-General:

(1) to intensify cooperation in the health sphere with the front-line States, with Lesotho and with Swaziland, and especially with the countries subjected to repeated aggression by the racist regime of South Africa and the illegal regime in Southern Rhodesia;

(2) to give special priority to the front-line States, Lesotho and Swaziland in programmes of health assistance to the African Region of WHO;

(3) to continue doing everything in his power to obtain governmental and nongovernmental support for an emergency assistance programme to the front-line States, Lesotho and Swaziland;

(4) to report to the Thirty-third World Health Assembly on the implementation of this resolution.

Hbk Res., Vol. II (3rd ed.), 1.4.2

(Twelfth plenary meeting, 22 May 1979 - Committee B, fourth report)

WHA32.21 Cooperation with newly independent and emerging States in Africa: Liberation struggle in Southern Africa - II

The Thirty-second World Health Assembly,

Recalling the provisions of resolutions WHA29.23, WHA30.24 and WHA31.52;

Considering that the non-white populations of South Africa, Namibia and Zimbabwe continue to be denied the necessary medical services and that political prisoners in these countries are subjected to inhuman treatment and political assassination in violation of the Constitution of WHO and the Charter of the United Nations;

Considering further that developments in the situation in Southern Africa, resulting from open defiance by the racist regime in Pretoria and the illegal regime in Salisbury of WHO principles and resolutions, dangerously threaten the social and health conditions of the people of this region through starvation and mass bombing;

Recalling, finally, the relevant resolutions of the United Nations General Assembly and Security Council concerning the liberation movements recognized by the Organization of African Unity;

1. EXPRESSES its satisfaction with the concerted efforts made by the Director-General of WHO, the United Nations High Commissioner for Refugees, the United Nations Development Programme, the United Nations Children's Fund, the International Committee of the Red Cross, the League of Red Cross Societies and other associated bodies to cooperate with the national liberation movements recognized by the Organization of African Unity;

2. REQUESTS the Director-General:

(1) to give and intensify, in collaboration with the United Nations, the specialized agencies and other bodies, all necessary support in the health sector to the national liberation movements recognized by the Organization of African Unity, including cooperation in the technical field, in training and in provision of medical supplies;

(2) to ensure that this technical cooperation in all its forms is provided in the most expeditious and flexible way through simplified procedures;

(3) to present a comprehensive and detailed report to the Thirty-third World Health Assembly on the progress made in the implementation of this resolution;

3. INVITES the Director-General to pursue all possible efforts to enlist support from governmental and nongovernmental sources for this operation;

4. REITERATES its appeal to all Member States to make voluntary contributions to this programme.

Hbk Res., Vol. II (3rd ed.), 1.4.2

(Twelfth plenary meeting, 22 May 1979 - Committee B, fourth report)

WHA32.22 Cooperation with newly independent and emerging States in Africa: Liberation struggle in Southern Africa - III

The Thirty-second World Health Assembly,

Recalling resolutions 411 (1977), 428 (1978) and 448 (1979) of the United Nations Security Council;

Recalling further resolutions WHA30.24 and WHA31.52 of the World Health Assembly;

Reaffirming the right of the people of Zimbabwe to national independence, which would ensure its full contribution to the achievement of the objective of health for all by the year 2000;

URGES the Director-General:

(1) to reject any cooperation with or assistance to the so-called "black majority regime of Rhodesia-Zimbabwe" born of the April 1979 elections;

(2) to continue and intensify, in collaboration with the other organs of the United Nations system, WHO's assistance in the health sphere to the Patriotic Front of Zimbabwe as the sole representative of the Zimbabwean people;

(3) to report to the Thirty-third World Health Assembly on the implementation of this resolution.

Hbk Res., Vol. II (3rd ed.), 1.4.2

(Twelfth plenary meeting, 22 May 1979 - Committee B, fourth report)

WHA32.23 Supplementary budgetary requirements for 1979: Extended borrowing authority

The Thirty-second World Health Assembly,

Having considered the report of the Director-General on any further developments affecting the supplementary budgetary requirements for 1979, and the recommendations, on behalf of the Board, of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-second World Health Assembly;[1]

1. STRESSES the need to ensure the financing of the approved programme budget for 1979 and to this end urges all Member States which have not already done so to pay their assessed contributions as early as possible;

2. AUTHORIZES the Director-General, if the cash balance of the Working Capital Fund, and such internal borrowing as may be possible and practical under Financial Regulation 5.1, should prove to be temporarily inadequate to finance the approved programme budget for 1979, to borrow funds from governments, banks or other external sources;

3. DECIDES that repayment of such loans be made as soon as contributions received make this possible, and that such repayment will have priority over the repayment of funds borrowed internally pursuant to Financial Regulations 5.1 and 6.3;

[1] See Annex 1; see also document EB63/48, resolution EB63.R1.

4. DECIDES further that any interest due on such loans be charged to the Casual Income Account;

5. REQUESTS the Director-General to report any such borrowings to the Executive Board at its next session.

Hbk Res., Vol. II (3rd ed.), 2.3.8

(Thirteenth plenary meeting, 24 May 1979 - Committee B, fifth report)

WHA32.24 Coordination of activities with other organizations of the United Nations system and attainment of health for all by the year 2000

The Thirty-second World Health Assembly,

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

Reaffirming the statement in the Declaration of Alma-Ata to the effect that an acceptable level of health for all the peoples of the world by the year 2000 can be attained through fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts, and that a genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development, of which primary health care is an essential part;

Noting resolutions 33/72 A, 33/91 E, 33/71 H and 33/66 B and other resolutions adopted in recent years by the United Nations General Assembly on the maintenance and strengthening of peace, extension of détente, averting of the threat of nuclear war, prohibition of the development of new types of weapons of mass destruction, banning of aggressive military conflicts, and attainment of the objectives of true disarmament;

Recalling also the contribution that WHO has already made to the strengthening of peace and cooperation between nations, notably resolution WHA15.51 on the role of the physician in the preservation and promotion of peace, resolution WHA20.54 on weapons of mass destruction, and resolutions WHA22.58 and WHA23.53 on prohibition of the production and stockpiling of chemical and bacteriological (biological) weapons;

1. CALLS UPON Member States to redouble their efforts towards the establishing, maintaining and strengthening of peace throughout the world, the consolidation of international détente and the attainment of disarmament, with a view to creating the conditions for a large-scale release of resources which could be used for the development of public health in the world;

2. REQUESTS the Director-General to:

(1) prepare a report on the further steps which WHO, as a United Nations specialized agency, would be able to take in the interests of international socioeconomic development, and also with the aim of assisting in the implementation of the United Nations resolutions on the strengthening of peace, détente and disarmament;

(2) conduct a study for consideration by the Executive Board on the subject of the strengthening of WHO's cooperation with other organizations within the United Nations system in order to achieve the objective of health for all by the year 2000.

Hbk Res., Vol. II (3rd ed.), 8.1.1

(Thirteenth plenary meeting, 24 May 1979 - Committee B, fifth report)

WHA32.25 Health care of the elderly

The Thirty-second World Health Assembly,

Having noted resolution 33/52 adopted by the thirty-third session of the United Nations General Assembly, deciding to organize a World Assembly on the Elderly in 1982;

Recognizing the leadership role of WHO in the health care of the elderly, and in the hope that the United Nations will invite WHO to take a prominent role in organizing the Assembly;

Aware that both the absolute number and the proportion of older people are increasing in all regions of the world, while at the same time health and social support services are either lacking or deficient and need to be developed further;

Believing that by the year 2000 the populations of the developing and developed nations of the world will have increased significantly and thus will have to envisage critical problems in the promotion of health, economic and social policy;

Considering that attention must be given to prevention in the social, economic and health spheres, starting with young people, to develop lifelong patterns that will help avoid debilitating conditions of old age;

Considering that in addition to family care alternatives must go beyond institutional care, such as home care, day care and ambulatory care, to greatly improve the quality of life of the elderly;

Noting also that the World Assembly on the Elderly will focus attention on the health, social and economic needs of the elderly;

1. REQUESTS the Director-General:

(1) to continue to support the important efforts by WHO already under way in this area and to mobilize the extra resources, both budgetary and extrabudgetary, which will be required;

(2) to undertake activities in collaboration with the United Nations and other organizations for appropriate participation in the Assembly;

(3) to consider the selection of "Health of the aged" as the theme for World Health Day, 1982;

(4) to take appropriate measures to maximize the activity of the global programme, which is aimed at improving the health care and health status of the older populations of all nations;

(5) to make use of present information systems to obtain and disseminate information on health problems and care of the aged;

(6) to promote activities for determining effective approaches for providing health care to the elderly, including integration into primary health care;

(7) to encourage comparative studies which provide a better understanding of the ways in which the elderly differ in physiological and pathological functions, as, for example, in absorption, effectiveness and metabolism or excretion of drugs;

(8) to encourage studies of the life histories of the healthy elderly to promote understanding of the factors able to prevent sickness and disability in later life;

(9) to encourage participation by WHO in workshops and conferences composed of representatives of national governments and international organizations for the purpose of discussing alternatives to institutional care for providing social security and minimum incomes, housing, health care, including maintenance of physical activity, meals, homemaker services, transportation and other needed services;

(10) to transmit to the Secretary-General of the United Nations the text of the present resolution, with a view to ensuring that WHO assumes an appropriate role in the preparations for the World Assembly;

(11) to report to the sixty-fifth session of the Executive Board and the Thirty-third World Health Assembly on the status of the preparations undertaken for the World Assembly;

2. URGES Member States:

(1) to undertake similar actions in their nations;

(2) to explore alternative services and systems of health care for the elderly including arrangements for optimum coordination between them;

(3) to promote activities and programmes that may help individuals to get prepared in time for later life;

(4) to encourage efforts directed at retaining or changing attitudes and behaviour among some segments of the population toward the elderly, particularly education of families and communities with a view to accepting the elderly as an integrated part of the community;

(5) to promote the development of informational materials including a glossary of terms about the elderly that can be widely disseminated;

(6) to emphasize through local medical and health-related groups the importance of diagnosis of problems that, if not treated, can contribute to long-term debilitating problems in the elderly;

(7) to take measures to have health professional schools include appropriate content on aging in basic clinical and social science courses that integrate knowledge about aging and the problems of the elderly, thus helping to assure an early commitment in the areas of prevention and gerontology.

Hbk Res., Vol. II (3rd ed.), 1.6.4.3

(Thirteenth plenary meeting, 24 May 1979 - Committee B, fifth report)

WHA32.26 Method of work of the Health Assembly - I

The Thirty-second World Health Assembly,

Recalling resolutions WHA3.96, WHA5.22, WHA6.57, WHA11.25 and WHA12.38;

Considering the increase in meetings on health matters organized at both the regional and international levels at which countries are required to be represented;

Bearing in mind the consequent heavy demands on human and financial resources required for attending such meetings which may create problems, particularly for developing countries;

Noting further that the question of holding biennial rather than annual Health Assemblies is included in the study of WHO's structures in the light of its functions which is to be reviewed by the regional committees in 1979, and by the Executive Board at its sixty-fifth session and the Thirty-third World Health Assembly in 1980 pursuant to resolution WHA31.27;

1. REQUESTS the Director-General in carrying out his study on the Organization's structures in the light of its functions to be submitted to the Executive Board at its sixty-fifth session to consider carefully the problem of the periodicity of Health Assemblies, taking into account the need for increased participation by Member States in the life of their Organization and the budgetary implications of the various alternatives; and include the possibility of rescheduling the work of the Assembly to permit the election of Members entitled to designate a person to serve on the Executive Board and the other agenda items assigned to the plenary meeting to be completed within the first week of the Assembly;

2. REQUESTS the Executive Board in its review of the above study to give due attention to the above questions in reporting to the Thirty-third World Health Assembly on WHO's structures in the light of its functions.

Hbk Res., Vol. II (3rd ed.), 4.1.3; 4.1.1.3 (Thirteenth plenary meeting, 24 May 1979 - Committee B, fifth report)

WHA32.27 Technical cooperation among developing countries

The Thirty-second World Health Assembly,

Taking into consideration the conclusions and recommendations of the United Nations Conference on Technical Cooperation among Developing Countries, held in Buenos Aires from 30 August to 12 September 1978;

Conscious of the urgent need of developing countries to mobilize all national and international resources towards the objectives of achieving the cherished goal of health for all by the year 2000;

Aware that technical cooperation among developing countries is an essential element in fostering individual and collective self-reliance on the part of the developing countries;

Recalling that the Health Assembly in repeated resolutions (WHA28.75, WHA28.76, WHA29.48, WHA30.30, and WHA30.43) has urged that, in order to redress the glaring inequalities and imbalances between the developed and developing countries, the programmes and activities of WHO be focused in ever-increasing measure towards the betterment of health conditions in developing countries;

Stressing that such betterment is possible only through location of more and more programmes and activities in developing countries, and maximum utilization of experts, institutions and local resources available in these countries, as well as through fostering the generation of these human and material resources where they do not exist;

Drawing attention also to resolutions WHA30.40 and WHA31.35, which lay stress on the setting of research goals and priorities in the regions in response to the expressed needs of Member States, and urge the balanced geographical distribution of collaborating centres in the field of biomedical and health services research;

1. ENDORSES the Buenos Aires Plan of Action as an important instrument of the international community for making international cooperation for development more effective;

2. EMPHASIZES that the progress in the redistribution of resources has been far from adequate in that resources allocated for developing countries by WHO and other international

organizations are not sufficiently directed to these countries, as has happened in some programmes;

3. URGES the Director-General:

(1) to promote the distribution of budgetary and extrabudgetary resources including those allocated to Special Programmes equitably to developing countries, particularly those most in need;

(2) to ensure such a rational distribution of funds, to shift as expeditiously as possible the major programmes, as well as the required resources, to the regional centres;

(3) to work out proposals in the contemplated restructuring of WHO to reduce the inadequate and intolerably inequitable distribution of health resources throughout the world:

(a) by further improving and streamlining the structures of the Organization and particularly at the regional level;

(b) by establishing within existing budgetary provisions at the regional offices of WHO focal points for the promotion of technical cooperation in health matters among developing countries with special regard to the exchange of relevant information and for the support of such cooperation by developed countries;

(c) by ensuring that regular programme budget funds for technical cooperation which have been released as a result of the implementation of resolution WHA29.48 are effectively absorbed by country and intercountry programmes;

(d) by taking into account, in the process of preparation of the Seventh General Programme of Work, and in all his efforts to support countries in the implementation of the new international development strategy, the deliberations on this subject at the Technical Discussions held during the Thirty-second World Health Assembly.

Hbk Res., Vol. II (3rd ed.), 1.4.1

(Thirteenth plenary meeting, 24 May 1979 - Committee B, fifth report)

WHA32.28 Appropriation Resolution for the financial period 1980-1981

The Thirty-second World Health Assembly

RESOLVES to appropriate for the financial period 1980-1981 an amount of US $477 378 400 as follows:

A.

Appropriation section	Purpose of appropriation	Amount US $
1.	Policy organs	10 128 600
2.	General programme development, management and coordination	56 025 900
3.	Development of comprehensive health services	77 994 100
4.	Disease prevention and control	76 806 600
5.	Promotion of environmental health	26 157 000
6.	Health manpower development	52 362 500
7.	Health information	42 881 000
8.	General services and support programmes	84 934 300
	Effective working budget	427 290 000
9.	Transfer to Tax Equalization Fund	40 000 000
10.	Undistributed reserve	10 088 400
	Total	477 378 400

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 1980 - 31 December 1981 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 1980-1981 to sections 1-9.

C. Notwithstanding the provisions of Financial Regulation 4.5, the Director-General is authorized to make transfers between those appropriation sections that constitute the effective working budget up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made, this percentage being established in respect of section 2 exclusive of the provision made for the Director-General's and Regional Directors' Development Programmes (US $7 543 600). The Director-General is also authorized to apply amounts not exceeding the provision for the Director-General's and Regional Directors' Development Programmes to those sections of the effective working budget under which the programme expenditure will be incurred. All such transfers shall be reported in the financial report for the financial period 1980-1981. 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:

reimbursement of programme support costs by the United Nations Development Programme in the estimated amount of . . . . . US $4 400 000

thus resulting in assessments on Members of US $472 978 400. 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.

Hbk Res., Vol. II (3rd ed.), 2.3.9

(Thirteenth plenary meeting, 24 May 1979 - Committee A, second report)

WHA32.29 Tentative budgetary projections for the financial period 1982-1983

The Thirty-second World Health Assembly,

Having considered the recommendations of the Executive Board on the appropriate rate of growth for the WHO regular programme budget in 1982-1983;[1]

Stressing the central importance of the WHO regular budget in enabling the Organization to carry out its worldwide functions;

DECIDES that the regular programme budget for 1982-1983 should be developed within a budgetary level that will provide for a real increase of up to 4% for the biennium, in addition to reasonably estimated cost increases, the underlying factors and assumptions of which should be made explicit.

Hbk Res., Vol. II (3rd ed.), 2.3

(Thirteenth plenary meeting, 24 May 1979 - Committee A, second report)

WHA32.30 Formulating strategies for health for all by the year 2000

The Thirty-second World Health Assembly,

Recalling resolution WHA30.43 by which the Thirtieth World Health Assembly decided that the main social target of governments and of WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life;

Having considered the report of the International Conference on Primary Health Care;[2]

Noting with appreciation the preliminary document of the Executive Board entitled "Formulating strategies for health for all by the year 2000";[3]

1. DECIDES that the development of the Organization's programmes and the allocation of its resources at global, regional and country levels should reflect the commitment of WHO to the overriding priority of the achievement of health for all by the year 2000;

2. ENDORSES the report of the International Conference on Primary Health Care including the Declaration of Alma-Ata, which:

(1) states that primary health care, forming as it does an integral part both of countries' health systems, of which it is the central function and main focus, and of overall social and economic development, is the key to attaining an acceptable level of health for all;

(2) calls upon all governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors;

(3) calls for urgent and effective national and international action to develop and implement primary health care throughout the world, and particularly in developing countries, in a spirit of technical cooperation and in keeping with a New International Economic Order;

[1] See document EB63/48, resolution EB63.R16 and Annex 5.

[2] Alma-Ata 1978: Primary health care. Geneva, World Health Organization, 1978.

[3] See Annex 2.

(4) recommends that WHO and the United Nations Children's Fund should continue to encourage and support national strategies and plans for primary health care as part of overall development, and should also formulate as soon as possible appropriate plans of action at the regional and global levels to promote and facilitate the mutual support of countries for accelerated development of primary health care;

3. THANKS the Government of the Union of Soviet Socialist Republics once again for its invitation and for the excellent facilities provided for the International Conference on Primary Health Care, which contributed greatly to its success, as well as for the opportunity afforded to participants in the Conference to acquaint themselves with examples of the health care system for the population;

4. BELIEVES that the exchange of experience between participants from various countries at the Alma-Ata Conference through the discussions in plenary and in the committees, as well as through national and regional reports, international exhibitions, and visits to health establishments in the course of field trips, should serve as an encouragement, particularly to developing countries, that it is possible to organize effective primary health care as part of the national health system within a period of time that is short in a historical perspective;

5. CONSIDERS that, in accordance with the basic policy of adapting international activities to the real needs of countries, strategies and plans of action for attaining health for all by the year 2000 should be formulated first and foremost by the countries themselves, and that the regional and global strategies formulated on the basis of these national strategies, as well as on the basis of the strategies of regional groups formed by countries for practical reasons, should promote and facilitate accelerated development of primary health care in the Member States of WHO, as well as the attraction of substantial and continuing additional international resources for these purposes;

6. CONSIDERS that the proposals of the Executive Board contained in its preliminary document entitled "Formulating strategies for health for all by the year 2000" concerning guiding principles for the formulation of effective strategies at the national, regional and global levels are a sound basis for the development and refinement of these strategies;

7. PROPOSES to the governments of Member States and to the regional committees and Executive Board of WHO that, in accordance with their constitutional functions, they should study these proposals in the light of the timetable contained in the document and present their further proposals concerning the coordinated development of strategies to the Thirty-third World Health Assembly;

8. INVITES Member States to consider the immediate use of the document entitled "Formulating strategies for health for all by the year 2000", individually as a basis for formulating national policies, strategies and plans of action, and collectively as a basis for formulating regional and global strategies;

9. REQUESTS the Executive Board:

(1) to submit proposals for the global strategy to the Thirty-fourth World Health Assembly and to support the Health Assembly in developing, implementing, monitoring and evaluating this strategy;

(2) to make sure that the global strategy is taken fully into account in preparing the Seventh General Programme of Work covering a specific period;

(3) to ensure that the global strategy is fully reflected in WHO's contribution to the preparation of the new international development strategy of the United Nations;

10. APPEALS to all agencies and organizations within the United Nations system, and in particular the United Nations Children's Fund and the United Nations Development Programme, as well as to all bilateral agencies and nongovernmental organizations concerned, to give full support to the formulation and implementation of national, regional and global strategies for

achieving an acceptable level of health for all, and pledges WHO's full cooperation with these bodies in such joint endeavours;

11. RECOGNIZES the necessity of careful planning, management and effective use of available resources, including those from national, bilateral, and international sources, for achievement of health for all;

12. REQUESTS the Director-General:

(1) to devote a predominant proportion of the funds of the Director-General's and Regional Directors' Development Programmes to ensuring the development and implementation of strategies for health for all;

(2) to develop a preliminary plan to ensure the appropriate allocation of funds for this purpose in the implementation of the approved 1980-1981 budget and in the formulation of the projected 1982-1983 budget, and submit this plan to the sixty-fifth session of the Executive Board;

(3) to take all the technical and administrative measures required to promote, coordinate, and support the formulation and implementation of national policies, strategies and plans of action and of regional and global strategies;

(4) to support the establishment of national health development centres of the type proposed in the above-mentioned document, and to consider organizing them in regional and global networks as suggested in this document;

(5) to facilitate the full exchange of information among Member States concerning the formulation and implementation of strategies and plans of action;

(6) to foster the intensification of research and training in primary health care at national, regional and global levels, making use in particular of appropriate collaborating centres;

(7) to propose measures, in agreement with the United Nations and related organizations, such as the United Nations Children's Fund, the United Nations Development Programme, the Food and Agriculture Organization of the United Nations, the United Nations Educational, Scientific and Cultural Organization, and the World Bank, as well as with other interested international agencies, for joint action to accelerate the development of primary health care in the developing, and especially the least developed, countries;

(8) to submit a report on the strategies formulated for attaining health for all by the year 2000 to the United Nations Preparatory Committee for inclusion in the new international development strategy, which is to be considered by the United Nations General Assembly at its thirty-fifth session in 1980;

(9) to make sure that the Secretariat at all operational levels provides the necessary support to countries, regional committees, the Executive Board and the Health Assembly for the formulation of national, regional and global strategies;

(10) to ensure that the Secretariat acts as an efficient instrument to give effect to the resolutions and decisions of the regional committees, the Executive Board, and the Health Assembly concerning strategies for health for all by the year 2000 and in carrying out those aspects of the national, regional and global strategies that are assigned to it by these bodies;

(11) to prepare and present to a future Health Assembly a progress report on the implementation of this resolution.

Hbk Res., Vol. II (3rd ed.), 1.1; 1.6.1

(Fourteenth plenary meeting, 25 May 1979 - Committee A, third report)

WHA32.31 Review of the medium-term programme for the promotion of environmental health

The Thirty-second World Health Assembly,

Having noted the global medium-term programme for the promotion of environmental health, the comments of the Executive Board thereon, and resolution EB63.R18;

1. COMMENDS the Director-General on his report;

2. ENDORSES the programme as presented;

3. URGES Member States:

(1) to continue close collaboration with WHO in achieving the objectives and targets set out in the medium-term programme;

(2) to give particular consideration to the programming of WHO resources at the country level for implementing this programme, ensuring in this process that the priorities established collectively by the Health Assembly are fully taken into account;

(3) to further ensure that in the planning and implementing of environmental health programmes full advantage is taken of multisector and multiagency participation;

4. INVITES the WHO regional committees to give appropriate attention to this matter;

5. REQUESTS the Director-General:

(1) to continue to give due attention to the relationship between health and environmental factors as a basis for the future development of this programme;

(2) to implement the programme, giving particular attention to:

(a) directing available resources at all levels within the Organization towards the targets set forth in the medium-term programme;

(b) taking the necessary steps to translate the medium-term programme into subsequent programme budgets, including the mobilizing of additional resources;

(c) coordinating activities in this field with other priorities of the Organization with a view to meeting needs of both the developing and the developed countries, and attaining the goal of health for all by the year 2000;

(d) coordination with other international intergovernmental and nongovernmental organizations involved.

Hbk Res., Vol. II (3rd ed.), 1.12.1

(Fourteenth plenary meeting, 25 May 1979 - Committee A, third report)

WHA32.32 Smallpox eradication

The Thirty-second World Health Assembly,

Having examined the report of the Director-General on the smallpox eradication programme;

Stressing that the achievement of global smallpox eradication is the result of the commitment of all nations involved in this programme;

1. ENDORSES resolution EB63.R5, including the recommendations of the Global Commission for the Certification of Smallpox Eradication annexed thereto;[1]

2. REQUESTS the Director-General:

(1) to consider how best to give full recognition, during the Thirty-third World Health Assembly, to the achievement of global eradication of smallpox, including a review of the lessons learned from the programme;

(2) to present a plan to that Health Assembly for the implementation of measures to ensure the permanence of smallpox eradication in the post-eradication era.

Hbk Res., Vol. II (3rd ed.), 1.10.4

(Fourteenth plenary meeting, 25 May 1979 - Committee A, third report)

WHA32.33 Respiratory diseases

The Thirty-second World Health Assembly,

Concerned about the high morbidity and mortality from respiratory diseases in particular because acute respiratory infections are among the most important causes of death in infants and young children;

Recognizing that respiratory diseases constitute a serious socioeconomic and public health problem in both developing and developed countries since they cause excessive absence from work and premature invalidity, draw substantially on medical care services, and, therefore, call heavily upon social and health insurances and cause considerable losses to national economies;

Recalling the effect of both active and passive smoking on the development of respiratory diseases, especially on their chronic form;

Endorsing the priority given to these problems in WHO's Sixth General Programme of Work;

Noting with satisfaction the action already taken by the Organization at the national, regional and global levels in preparing for a major control programme of respiratory diseases;

Conscious that the application of innovative, simple and effective measures for the prevention and control of respiratory diseases would constitute an important element in increasing the effectiveness and acceptability of primary health services;

1. REQUESTS the Director-General:

(1) to stimulate and to intensify the involvement of Member States in the control of respiratory diseases, and to promote technical cooperation with them as well as among them, in respect of the formulation of national control programmes, with particular reference to their integration into current and future development activities in health and other fields;

(2) to accord high priority to research activities for the development of effective methods for the prevention of acute and chronic respiratory diseases, their timely detection and diagnosis, and appropriate curative services, e.g. optimal package treatment;

[1] Document EB63/48, p. 7.

(3) to keep the Executive Board and the Health Assembly informed of the progress made in the development and implementation of the programme on respiratory diseases;

2. CALLS UPON the United Nations Development Programme, the World Bank, the United Nations Children's Fund, the United Nations Fund for Population Activities, and other international organizations and funds to actively support this new programme, as a major element of primary health care;

3. URGES Member States to give a high priority to the control of respiratory diseases and to establish national targets in terms of reduction of morbidity and mortality.

Hbk Res., Vol. II (3rd ed.), 1.10.3; 1.11 (Fourteenth plenary meeting, 25 May 1979 - Committee A, third report)

WHA32.34 Emergencies caused by yellow fever and other communicable diseases

The Thirty-second World Health Assembly,

Noting with deep concern the recent epidemics of yellow fever in a number of West African countries and in the Region of the Americas;

Recognizing the need for urgent intensified action to control the disease in those countries where it is still endemic, and for the prevention of a deterioration of the epidemiological situation in other countries;

Noting with satisfaction the action taken by the Director-General in accordance with resolution WHA23.34;

Noting the Organization's activities in the field of surveillance and control of communicable diseases;

Taking cognizance of WHO's emergency scheme for epidemics being prepared in collaboration with Member States and the valuable supporting role of the WHO collaborating centres and other advisory services as technical resources;

Realizing the need for close international cooperation and collaboration in communicable disease surveillance and control;

Considering that emergencies caused by communicable diseases may require resources beyond those currently available to national health authorities;

1. THANKS the Director-General for the prompt action and collaboration with the affected countries to bring the epidemics under control;

2. URGES all Member States where the disease is endemic to pursue the anti-yellow fever surveillance and control efforts on a more realistic basis and provide the national priority required on a continuing basis, and to make use of WHO emergency services whenever conditions call for this;

3. REQUESTS the Director-General:

(1) to develop further the recommendations contained in resolution WHA23.34, and in particular the support of advisory services and the provision of yellow fever vaccine approved by WHO;

(2) to cooperate with countries in developing realistic approaches to the surveillance and control of yellow fever and other communicable diseases with epidemic potential.

Hbk Res., Vol. II (3rd ed.), 1.10.3.6 (Fourteenth plenary meeting, 25 May 1979 - Committee A, third report)

WHA32.35 Development of the malaria action programme in Africa

The Thirty-second World Health Assembly,

Noting with grave concern that, in spite of the recommendations of resolution WHA31.45 adopted by the Thirty-first World Health Assembly and numerous previous resolutions on the subject, organized antimalaria activities are yet to be initiated by most countries in the African Region where the havoc caused by the disease is greatest;

Realizing that many African countries are faced with complex financial, administrative, technical and operational problems in connexion with the planning, implementation and evaluation of realistic and flexible antimalaria activities in accordance with the new tactical variants developed by the Organization;

Realizing further that, unless the African countries are assisted to implement realistic antimalaria activities, the situation will further deteriorate and consequently jeopardize the achievement of the goal of health for all by the year 2000;

1. URGES Member States:

(1) to establish technical cooperation for the urgent development of realistic antimalaria activities in the spirit of resolutions WHA31.41 and EB63.R31 on technical cooperation among developing countries and based on technical guidelines developed by WHO's malaria action programme;

(2) to intensify coordination with WHO and other international, bilateral and voluntary agencies in the mobilization of the necessary resources in support of antimalaria activities, including the production of antimalarial drugs and insecticides in countries in need of such supplies;

(3) to intensify cooperation and collaboration with WHO and other cooperating agencies as appropriate;

2. REQUESTS the Director-General:

(1) to establish a special task force for cooperation and collaboration with Member States in Africa in the development of organized antimalaria activities;

(2) to strengthen further WHO's functional structure, particularly at the regional level, so as to gear the Organization to undertake the maximum possible comprehensive, purposeful and effective action, with the goal of speedy combat of the disease;

(3) to give even higher priority to the malaria control programme in future programme budgets;

(4) to intensify active coordination of malaria control activities with those of the Special Programme for Research and Training in Tropical Diseases and other research projects in order to ensure the quickest possible implementation of any new technology;

(5) to explore every possibility of securing additional extrabudgetary funds for the malaria action programme;

(6) to report to the Executive Board and the Health Assembly on the progress made.

Hbk Res., Vol. II (3rd ed.), 1.10.2.1

(Fourteenth plenary meeting, 25 May 1979 - Committee A, third report)

WHA32.36 Method of work of the Health Assembly - II

The Thirty-second World Health Assembly,

Having considered the recommendations of the Executive Board[1] concerning the method of work of the Health Assembly;

Believing that the proposed changes in respect of the proceedings of the Health Assembly would contribute towards further rationalizing and improving the work of the Assembly;

1. DECIDES that:

(1) neither main committee of the Health Assembly shall meet during plenary meetings of the Health Assembly, and that this provision supersedes paragraph II.1 of resolution WHA28.69;

(2) the role and functions of the rapporteurs of the main committees of the Health Assembly may include:

(a) participation in the preparation and presentation of draft resolutions;

(b) participation in any working groups which may be set up to prepare draft resolutions or to reconcile amendments to such resolutions;

(3) Executive Board representatives should help sponsors of draft resolutions by drawing attention to the existence of recent reports which might make a request for a further report on the same subject unnecessary, and to previously adopted resolutions or decisions that would appear to render the adoption of a new resolution unnecessary;

(4) informal meetings between delegates and the Secretariat on technical questions shall continue to be held in accordance with existing arrangements;

(5) the earlier practice of holding the Technical Discussions in small groups shall be resumed, and reports or accounts of the Technical Discussions shall continue to be published;

(6) the Board shall fix a preliminary daily timetable for the Health Assembly's consideration of its agenda and the General Committee shall review and approve this timetable, subsequently revising it if and when required;

(7) the Executive Board, when preparing the provisional agenda of each regular session of the Health Assembly, shall take into consideration the desirability of achieving an appropriate balance in the volume of work in the Health Assembly from year to year, and in this connexion, as a general principle, individual technical programme items shall preferably be included in the agenda of the Health Assembly as separate items only in the years when the Health Assembly does not undertake a full review of the proposed biennial programme budget, thus allowing more time for such technical items and providing a better balance of work of the Health Assembly;

(8) the members of the Committee on Nominations shall ascertain that the delegates they propose as officers of the Health Assembly are willing, barring unforeseen circumstances, to discharge the responsibilities of the office concerned for the entire duration of the Assembly;

[1] See document EB63/48, resolution EB63.R33 and Annex 12.

2. DECIDES FURTHER to amend the following Rules of Procedure of the Health Assembly to read:

(1) Rule 5 (f): "any item proposed by any other organization of the United Nations system with which the Organization has entered into effective relations";

(2) Rule 33 (c): "propose to the Health Assembly the initial allocation to committees of items of the agenda, and if appropriate the deferment of any item to a future Health Assembly";

(3) Rule 36: "Each main committee shall, after consideration of the report of the Committee on Nominations, elect two vice-chairmen and a rapporteur";

(4) the first sentence of Rule 45: "Representatives of the Board may attend plenary meetings and meetings of the General Committee and main committees of the Health Assembly";

(5) the first sentence of Rule 77: "After the voting has been completed, a delegate may make a brief statement, consisting solely of an explanation of vote".

Hbk Res., Vol. II (3rd ed.), 4.1.3; 4.1.2; 4.1.4; 4.2.6

(Fourteenth plenary meeting, 25 May 1979 - Committee B, sixth report)

WHA32.37 Recruitment of international staff in WHO

The Thirty-second World Health Assembly,

Convinced of the importance of equitable geographical distribution of WHO international staff for all activities of the Organization;

Recalling resolution 31/26 of the United Nations General Assembly as well as Executive Board resolutions EB57.R52, EB59.R51 and EB63.R25,[1] which contain guiding principles for WHO international staff recruitment;

Noting with satisfaction that the Director-General has established, and the Executive Board has approved, for the purpose of geographical distribution, desirable ranges similar to those applied by the United Nations but adapted to WHO's membership and the size of its Secretariat;

Concerned also at the slow progress in correcting a serious imbalance in geographical distribution of WHO Secretariat posts, which precludes the attainment of appropriate representation of unrepresented and under-represented countries within the time-limit approved by the United Nations;

Further convinced that WHO, as a United Nations specialized agency, should follow the United Nations principles of recruitment of international personnel;

Recalling that Article 101 (3) of the Charter of the United Nations provides that "The paramount consideration in the employment of the staff and in the determination of the conditions of service shall be the necessity of securing the highest standards of efficiency, competence, and integrity" and that "Due regard shall be paid to the importance of recruiting the staff on as wide a geographical basis as possible";

[1] See also document EB63/48, Annex 10.

1. REQUESTS the Director-General to continue and intensify his efforts to correct the existing geographical imbalance of WHO international staff, following as closely as possible the practices accepted by the United Nations in order to reach the equitable geographical distribution of this staff in the shortest time practicable, giving particular preference to candidates from the developing and other under-represented countries;

2. REQUESTS the Executive Board to review annually the status of international staff recruitment and to report to the Health Assembly thereon;

3. REQUESTS the sixty-fifth session of the Executive Board to re-examine the concept of desirable ranges relating to the appointment of international staff, in view of the ongoing study on the structure of WHO in the light of its functions.

Hbk Res., Vol. II (3rd ed.), 7.2.2.1

(Fourteenth plenary meeting, 25 May 1979 - Committee A, fourth report)

WHA32.38 Organization of a world fortnight on hygiene and cleanliness

The Thirty-second World Health Assembly,

Recalling resolutions EB63.R18 and EB63.R32 on the promotion of environmental health;

Bearing in mind the priority assigned to preventive activities and to the many aspects of health education;

Considering the major objective of primary health care, which envisages the participation of all sections of the population;

Encouraged by the efforts made to protect nature and the environment, regarded as a prerequisite for harmonious development;

1. RECOMMENDS to all Member States to strengthen the existing measures for the continuous promotion of environmental health and to organize a world fortnight on hygiene and cleanliness, backed by the public health authorities in conjunction with the services responsible for environmental protection and with all interested bodies;

2. REQUESTS the Director-General to collaborate with countries by promoting the dissemination of all types of information capable of mobilizing populations to promote the development of mass health education concerning hygiene and cleanliness.

Hbk Res., Vol. II (3rd ed.), 1.12.1; 1.12.2

(Fourteenth plenary meeting, 25 May 1979 - Committee A, fourth report)

WHA32.39 Leprosy

The Thirty-second World Health Assembly,

Recalling resolutions WHA29.70 and WHA30.36 and other previous resolutions of both the Health Assembly and the Executive Board:

Noting:

(a) the progress made throughout the world since the adoption of the above resolutions - particularly in studies of ultrastructure, histochemistry, bacteriology, immunology, chemotherapy and prophylaxis;

(b) that leprosy, in spite of such advances, is still a major public health and social problem in some countries of Africa, Asia, Latin America and the Pacific islands;

(c) that urgent and resolute steps will be necessary to control leprosy if the concept of health for all by the year 2000 is to become a practical possibility, since the periods of incubation and infectivity of leprosy may extend up to a considerable number of years;

1. URGES Member States with endemic leprosy:

(1) to allocate adequate resources to carry out effective leprosy programmes, including training of their own personnel;

(2) to support treatment, physical and social rehabilitation and vocational programmes for leprosy patients to make them self-reliant and self-supporting;

(3) to review the current practices of isolation of leprosy patients in specialized institutions, where this exists, in order to achieve their progressive integration as active and fully accepted members of society;

2. REQUESTS the Director-General:

(1) to intensify the Organization's activities for leprosy control in the next decade, as a contribution to the attainment of the objective of health for all by the year 2000;

(2) to cooperate with Member States with endemic leprosy to develop effective programmes for prevention and treatment of leprosy;

(3) to continue to mobilize resources from extrabudgetary sources both for the leprosy control programme and for the Special Programme for Research and Training in Tropical Diseases, particularly for epidemiological surveys and chemotherapeutic trials, and to promote relevant research for the development of new drugs as well as in the field of immunology with the objective of producing a vaccine for prophylaxis;

(4) to report to the Thirty-fifth World Health Assembly on the steps taken.

Hbk Res., Vol. II (3rd ed.), 1.10.3.1

(Fourteenth plenary meeting, 25 May 1979 - Committee A, fourth report)

WHA32.40 Development of the WHO programme on alcohol-related problems

The Thirty-second World Health Assembly,

Recognizing that problems related to alcohol, and particularly to its excessive consumption, rank among the world's major public health problems;

Recalling resolutions WHA28.81, WHA28.84, WHA29.21 and EB63.R30 concerning, respectively, health statistics related to alcohol, the promotion of mental health, psychosocial factors and health, and the development of WHO's programme on alcohol-related problems;

Appreciating the work already carried out by the Organization and nongovernmental organizations on alcohol-related problems;

Noting the discussions of the Executive Board concerning the need to develop further the WHO programme on the above-mentioned problems;

1. AFFIRMS that problems relating to alcohol consumption, including health, social and economic consequences, constitute serious hazards for human health, welfare and life, and that it is necessary, therefore, for Member States to pay greater attention to these problems;

2. URGES Member States:

(1) to take all appropriate measures to reduce the consumption of alcohol among all sectors of the population, but especially among young people, adolescents and pregnant women;

(2) to develop intensive preventive programmes that include public information and education concerning alcohol problems, and ensure the provision of appropriate legislation and other measures enabling effective action to be taken, for example in relation to the production and sale of alcoholic beverages;

(3) to undertake additional measures for the prevention, control and management of such problems as may arise in relation to alcohol consumption, including the provision of treatment and rehabilitation services and the development of the necessary manpower within the context of health services;

(4) to develop and collect relevant and reliable statistical and other information related to alcohol consumption and its consequent problems;

(5) to study the behavioural and sociological factors contributing to alcohol abuse;

3. REQUESTS the Director-General:

(1) to strengthen WHO's capacity to respond to requests from governments to provide support for their efforts in dealing with the problems associated with alcohol;

(2) to encourage greater intercountry collaboration with respect to the prevention and treatment of alcohol-related problems by developing joint training programmes, reviewing existing trade practices and agreements relating to alcohol, establishing international criteria for reporting alcohol-related problems and levels of alcohol production, and ensuring the exchange of experience regarding particular preventive measures;

(3) to promote joint consideration by the organizations of the United Nations system and nongovernmental organizations of the problems associated with alcohol and their alleviation, and specifically to invite the United Nations Statistical Office, the International Labour Organisation, the Food and Agriculture Organization of the United Nations and the United Nations Educational, Scientific and Cultural Organization to collaborate with WHO in this work;

(4) to seek additional funds from the United Nations, particularly from the bodies concerned with drug dependence, and from governmental and nongovernmental sources, and to study the possibility of establishing a special fund within the United Nations system, concerned with alcohol-related problems including alcoholism;

(5) to report on these matters to future Health Assemblies as appropriate;

4. REQUESTS the Executive Board to consider "Alcohol consumption and alcohol-related problems" as the subject for Technical Discussions as early as possible.

Hbk Res., Vol. II (3rd ed.), 1.8.4.2

(Fourteenth plenary meeting, 25 May 1979 - Committee A, fourth report)

WHA32.41 Action programme on essential drugs

The Thirty-second World Health Assembly,

Recalling resolutions WHA31.32 and EB63.R20;

Convinced that an adequate supply of essential drugs is indispensable for attaining health for all by the year 2000;

1. ENDORSES resolution EB63.R20;

2. REITERATES the validity of the guiding principles embodied in resolution WHA31.32;

3. THANKS the Director-General for his progress report;

4. URGES Member States to take action in accordance with resolution WHA31.32 and to participate in the action programme on essential drugs, concentrating on ways and means of rational procurement, on more suitable training, and on fuller and more objective information of all health workers involved in the utilization of drugs;

5. REQUESTS the Director-General to establish a special programme on essential drugs, including its administrative structure,[1] and to make provision for the initial financing from the Director-General's and/or Regional Directors' Development Programmes, if necessary.

Hbk Res., Vol. II (3rd ed.), 1.9.1.1

(Fourteenth plenary meeting, 25 May 1979 - Committee B, seventh report)

WHA32.42 WHO long-term programme for maternal and child health

The Thirty-second World Health Assembly,

Recalling resolutions WHA27.43, WHA31.47 and WHA31.55;

Referring to the social target of health for all by the year 2000 and to the principles regarding primary health care adopted in 1978 at the International Conference for Primary Health Care, held in Alma-Ata;

Recognizing that maternal and child health care including nutrition, family planning and immunization are essential aspects of primary health care;

Convinced that a rapid development and determined strengthening of maternal and child health care are of paramount importance for attaining the goal of health for all by the year 2000;

Realizing that more than one-third of the world's population in the year 2000 is not yet born;

Recognizing also that maternal and child health is the health priority, firmly interrelated with the social and economic development of every country;

Recognizing that definite improvements in the health of mothers and children have been achieved where special efforts and resources have been committed to this area of health development;

[1] See document EB63/48, resolution EB63.R20, para. 3, and Annex 7, section 6.

Convinced that it is important to ensure continuation of the emphasis on the welfare of children started during the International Year of the Child;

Thanking the Director-General for his comprehensive and informative report providing the background for action now;[1]

1. URGES Member States:

(1) to further develop their overall health and socioeconomic planning giving due and explicit attention to meeting health and other needs of mothers, children and the family, and to ensure appropriate distribution of national resources to this end;

(2) to promote specific government regulations and laws to provide free health services at least during periods of high risk - pregnancy, delivery, and the first years of life when breastfeeding, immunization and treatment of infectious and parasitic diseases are crucial for survival;

(3) to promote the development of primary health care programmes with concrete plans for maternal and child health care as its essential component that includes care during pregnancy and childbirth, family planning, infant and child care with appropriate focus on improvement of nutrition, prevention of infections, promotion of physical and psychological development of the child, and education for family life;

(4) to ensure the development of appropriate supportive, referral and training services in paediatrics, obstetrics and other related subjects in line with principles of primary health care;

(5) to ensure active participation of individuals, families and communities in the development and utilization of maternal and child health care;

(6) to develop, as appropriate, health and related social services such as day-care services, school health services, and services for adolescents, and relevant social legislation in support of mothers and children;

(7) to encourage new approaches for simpler, more direct and massive actions to bring to those families, mothers and children most in need those essential health and educational services which are still unavailable to them and review when appropriate present utilization of all health personnel including traditional health workers in order to ensure a better use of existing resources for maternal and child health;

(8) to develop and strengthen the information support necessary for the planning and implementation of maternal and child care at different levels of the health care system;

(9) to include in the planned efforts for maternal and child health specific attempts to reach high-risk and underprivileged groups of mothers and children and their families, and to specifically support all efforts at improving the nutrition of pregnant and lactating mothers and of children;

(10) to support research and development as well as evaluation in the area of maternal and child health as part of health services research;

2. REQUESTS the Director-General:

(1) to support, in collaboration with the United Nations Children's Fund and the United Nations Fund for Population Activities, and competent nongovernmental organizations in official relations with WHO, and with Member States, the formulation and implementation of long-term maternal and child health programmes as part of the development of their strategies to reach the goal of health for all by the year 2000;

[1] See Annex 3.

(2) to support Member States in setting quantifiable targets and in the utilization of suitable indicators for monitoring the effectiveness of their activities in maternal and child health;

(3) to assist Member States in implementing the Expanded Programme on Immunization as an integral part of maternal and child health services;

(4) to assist Member States in implementing systematic and planned chloroquine chemoprophylaxis of malaria for children and pregnant mothers in highly malarious areas;

(5) to further support Member States in curricular revisions in teaching medical and health sciences to give wider coverage to family health and maternal and child health and in development of training programmes for all categories of workers in the health sector as well as other sectors aiming at the increase of their awareness of the relationship between health and socioeconomic factors with particular reference to the development of children;

(6) to further develop the Organization's activities for the development of appropriate technology in maternal and child health care and promote health services research in this field;

(7) to intensify efforts for providing additional support for the Organization's programme in maternal and child health and to mobilize scientific and financial resources in this field;

(8) to report progress in this work to a future Health Assembly.

Hbk Res., Vol. II (3rd ed.), 1.7.1

(Fourteenth plenary meeting, 25 May 1979 - Committee B, seventh report)

DECISIONS

(1) Composition of the Committee on Credentials

The Thirty-second World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Members: Belgium; Hungary; Lesotho; Nepal; Niger; Oman; Papua New Guinea; Sweden; Trinidad and Tobago; Tunisia; Upper Volta; and Venezuela.

(First plenary meeting, 7 May 1979)

(2) Composition of the Committee on Nominations

The Thirty-second World Health Assembly elected a Committee on Nominations consisting of delegates of the following 24 Members: Austria; Bolivia; Botswana; Brazil; Burma; China; Czechoslovakia; Fiji; France; Guinea-Bissau; Guyana; Iran; Maldives; Qatar; Saudi Arabia; Sierra Leone; Sudan; Togo; Union of Soviet Socialist Republics; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; and Zaire.

(First plenary meeting, 7 May 1979)

(3) Election of officers of the Thirty-second World Health Assembly

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

President: Professor P. Tuchinda (Thailand)

Vice-Presidents:

Mr Tan Yunhe (China), Mr F. Mebazaa (Tunisia), Dr I. Musafili (Rwanda), Mr E. Rivasplata Hurtado (Peru), Professor M. Sliwinski (Poland)

(Second plenary meeting, 8 May 1979)

(4) Election of officers of the main committees

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

COMMITTEE A: Chairman, Professor R. Senault (France)

COMMITTEE B: Chairman, Dr H. F. B. Martins (Mozambique)

(Second plenary meeting, 8 May 1979)

The main committees subsequently elected the following officers:

COMMITTEE A: Vice-Chairman, Dr J. M. Kasonde (Zambia); Rapporteur, Dr S. Azzuz (Libyan Arab Jamahiriya);

COMMITTEE B: Vice-Chairman, Dr M. Tottie (Sweden); Rapporteur, Dr J. M. Borgoño (Chile).

(First meetings of Committees A and B, 9 May 1979)

(5) Establishment of the General Committee

The Thirty-second World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the delegates of the following 16 countries as members of the General Committee: Argentina; Brazil; Bulgaria; Fiji; India; Iran; Jamaica; Libyan Arab Jamahiriya; Nigeria; Pakistan; Swaziland; Union of Soviet Socialist Republics; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; and Zaire.

(Second plenary meeting, 8 May 1979)

(6) Verification of credentials

The Thirty-second World Health Assembly recognized the validity of the credentials of the following delegations:

Members

Afghanistan; Albania; Algeria; Angola; Argentina; Australia; Austria; Bahrain; Bangladesh; Belgium; Benin; Bolivia; Botswana; Brazil; Bulgaria; Burma; Burundi; Canada; Cape Verde; Central African Empire; Chad; Chile; China; Colombia; Comoros; Congo; Costa Rica; Cuba; Cyprus; Czechoslovakia; Democratic People's Republic of Korea; Democratic Yemen; Denmark; Djibouti; Ecuador; Egypt; El Salvador; Ethiopia; Fiji; Finland; France; Gabon; Gambia; German Democratic Republic; Germany, Federal Republic of; Ghana; Greece; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran; Iraq; Ireland; Israel; Italy; Ivory Coast; Jamaica; Japan; Jordan; Kenya; Kuwait; Lao People's Democratic Republic; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Mauritania; Mauritius; Mexico; Monaco; Mongolia; Morocco; Mozambique; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Romania; Rwanda; Samoa; Sao Tome and Principe; Saudi Arabia; Senegal; Sierra Leone; Singapore; Somalia; Spain; Sri Lanka; Sudan; Suriname; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Thailand; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Uganda; Union of Soviet Socialist Republics; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Cameroon; United Republic of Tanzania; United States of America; Upper Volta; Uruguay; Venezuela; Viet Nam; Yemen; Yugoslavia; Zaire; and Zambia.

Associate Member

Namibia.

(Fourth, fifth and twelfth plenary meetings, 9 and 22 May 1979)

(7) Adoption of the agenda

The Thirty-second World Health Assembly adopted the provisional agenda prepared by the Executive Board at its sixty-third session with the addition of one item, the deletion of four items, and the rewording and renumbering of one item.

(Fifth plenary meeting, 9 May 1979)

(8) Award of the Léon Bernard Foundation Medal and Prize

The Thirty-second World Health Assembly, after considering the reports of the Léon Bernard Foundation Committee, awarded the Léon Bernard Foundation Medal and Prize for 1979 to Professor Bror Rexed, and paid a tribute to him for his outstanding contribution to the promotion of health and social medicine.

(Eighth plenary meeting, 15 May 1979)

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

The Thirty-second World Health Assembly, after considering the recommendations of the General Committee,[1] elected the following as Members entitled to designate a person to serve on the Executive Board: Colombia; Congo; Iran; Jamaica; Netherlands; New Zealand; Norway; Oman; Samoa; and Turkey.

(Ninth plenary meeting, 16 May 1979)

(10) Award of the Dr A. T. Shousha Foundation Medal and Prize

The Thirty-second World Health Assembly, after considering the reports of the Dr A. T. Shousha Foundation Committee, awarded the Dr A. T. Shousha Foundation Medal and Prize for 1979 to Dr Riad Ibrahim Husain, and paid tribute to him for his most significant contribution to public health in the geographical area in which Dr A. T. Shousha served the World Health Organization.

(Ninth plenary meeting, 16 May 1979)

(11) Report of the Director-General on the work of WHO in 1978

The Thirty-second World Health Assembly, after reviewing the Director-General's report on the work of the Organization in 1978,[2] noted with satisfaction the manner in which the Organization's programme for this year had been planned and implemented.

(Tenth plenary meeting, 17 May 1979)

[1] For report of the General Committee, see document WHA32/1979/REC/2.

[2] See Annex 4.

(12) Organizational study by the Executive Board on "The role of WHO expert advisory panels and committees and collaborating centres in meeting the needs of WHO regarding expert advice and in carrying out technical activities of WHO"

The Thirty-second World Health Assembly noted the progress made by the working group of the Executive Board on the organizational study on "The role of WHO expert advisory panels and committees and collaborating centres in meeting the needs of WHO regarding expert advice and in carrying out technical activities of WHO", and decided that the final report should be submitted to the Thirty-third World Health Assembly.

(Eleventh plenary meeting, 18 May 1979)

(13) Award of the Jacques Parisot Foundation Medal

The President of the Thirty-second World Health Assembly presented the Jacques Parisot Foundation Medal to Dr Manuel Flores Bonifacio, holder of the fellowship awarded by the Foundation in 1978.

(Eleventh plenary meeting, 18 May 1979)

(14) Annual report of the United Nations Joint Staff Pension Board for 1977

The Thirty-second World Health Assembly noted the status of the operation of the Joint Staff Pension Fund, as indicated by its annual report for the year 1977 and as reported by the Director-General.

(Thirteenth plenary meeting, 24 May 1979)

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

The Thirty-second World Health Assembly appointed Dr A. Sauter, in a personal capacity, as member of the WHO Staff Pension Committee, and the member of the Executive Board designated by the Government of Iran as alternate member of the Committee, the appointments being for a period of three years.

(Thirteenth plenary meeting, 24 May 1979)

(16) Health conditions of the Arab population in the occupied Arab territories, including Palestine

The Thirty-second World Health Assembly, bearing in mind resolutions of the Health Assembly on "Health conditions of the Arab population in the occupied Arab territories, including Palestine", and taking into consideration that the Special Committee of Experts had not pursued the study requested by resolution WHA31.38, requested the Special Committee of Experts to submit a report to the Thirty-third World Health Assembly, and decided to postpone the consideration of the item and to include it in the agenda of the Thirty-third World Health Assembly.

(Thirteenth plenary meeting, 24 May 1979)

(17) Reports of the Executive Board on its sixty-second and sixty-third sessions

The Thirty-second World Health Assembly, after reviewing the Executive Board's reports on its sixty-second[1] and sixty-third[2] sessions, approved the reports; commended the Board on the work it had performed; and requested the President to convey the thanks of the Health Assembly in particular to those members of the Board who would be completing their terms of office immediately after the closure of the Health Assembly.

(Thirteenth plenary meeting, 24 May 1979)

(18) Selection of the country in which the Thirty-third World Health Assembly will be held

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

(Thirteenth plenary meeting, 24 May 1979)

(19) Transfer of the Regional Office for the Eastern Mediterranean

The Thirty-second World Health Assembly, considering that the majority of Members of the Eastern Mediterranean Region wished the Regional Office to be transferred from Alexandria, Arab Republic of Egypt, to another State in the Region, and considering that it was necessary to study the effects of the implementation of such a decision by the Health Assembly, decided to request the Executive Board at its forthcoming session to undertake such a study, taking necessary steps for its implementation, and report its findings to the Thirty-third World Health Assembly.

(Fourteenth plenary meeting, 25 May 1979)

[1] WHO Official Records, No. 249, 1978.

[2] Executive Board, sixty-third session: Resolutions and decisions (document EB63/48); Report on the proposed programme budget for the financial period 1980-1981 (document EB63/49); and Summary records (document EB63/50).

ANNEXES

ANNEX 1

SUPPLEMENTARY BUDGETARY REQUIREMENTS FOR 1979:
EXTENDED BORROWING AUTHORITY[1]

[A32/36 - 7 May 1979]

Report of the Committee of the Executive Board to
Consider Certain Financial Matters prior to the Health Assembly

1. At its sixty-third session (January 1979) the Executive Board, in resolution EB63.R28,[2] established a committee consisting of Dr D. Galego Pimentel, Professor J. J. A. Reid, Dr D. B. Sebina and Dr M. Violaki-Paraskeva to consider on behalf of the Board inter alia the subject of "Report of the Director-General on any further developments that might affect the supplementary budgetary requirements for 1979". The Committee met on 7 May under the chairmanship of Professor J. J. A. Reid.

2. The Committee had before it a report of the Director-General (see Appendix). In examining this report the Committee recalled the previous discussions in the Executive Board and its Programme Committee concerning certain developments in the United States of America, whose legislative body had enacted legislation which, unless repealed, would reduce substantially that Member's contribution to the Organization's budget, and would attach to the remainder of the contribution the condition that it could not be used for "technical assistance". The Board had recognized that any substantial delay or shortfall in the payment of assessed contributions to the regular budget would affect the amount of casual income earned by the Organization, in which event the amount of such income available in 1979 might be insufficient to cover the anticipated budgetary loss for that year. Moreover, the withholding by Member States of contributions to WHO's regular budget could have serious financial implications for the Organization's ability to carry out its programme of activities in accordance with the approved programme budget policy and strategy. In expressing its concern at the debate which had occurred in some countries and forums which had questioned the appropriateness of technical cooperation forming any part of the regular budgets of the United Nations and its specialized agencies, including WHO, the Board had also stressed that the withholding of, or attachment of conditions to, all or part of the assessed contributions to the Organization's budget would clearly violate the international legal obligations which every Member State contracted when it joined the Organization and formally accepted its Constitution.

3. The Committee noted that, following the session of the Executive Board in January 1979, the Government of the United States of America had taken vigorous action in a legislative process that, it was hoped, would lead to the amendment of the earlier legislation and thus permit the full payment of its assessed contribution to WHO's regular budget as well as the elimination of the restrictive language relating to the utilization of the contribution. However, as the final outcome of this legislative process was not yet known, the Director-General considered it financially prudent and advisable to submit the proposals for an

[1] See resolution WHA32.23.

[2] Executive Board, sixty-third session: Resolutions and decisions (document EB63/48), p. 32.

extended borrowing authority described in his report, appended to this document, which would enable him to deal with a significant, temporary shortfall in the payment of assessed contributions to the regular budget that might occur in the course of 1979. In view of the legislative steps being taken by the United States of America as noted above, the Director-General believed that the problem was of a short-term nature and confined to the financing of the 1979 programme budget only. Under the circumstances, he did not propose any long-term arrangements nor did he consider that a change in the Financial Regulations was necessary at present.

4. As to the sources from which funds might be borrowed, the Committee recalled that the authority to borrow internally from funds available to the Organization had been incorporated in Financial Regulation 5.1 by the Twenty-ninth World Health Assembly (1976) in accordance with resolution WHA29.27. At that time, the Director-General had concluded that trust funds and other funds (including contributions to the Voluntary Fund for Health Promotion) required for the financing of programme activities should not be borrowed under the internal borrowing authority, since such funds had been made available to the Organization on terms which generally had been specified by the donors. The Director-General had again come to the conclusion that any extended borrowing authority granted to him should also exclude voluntary funds and trust funds which were to be used for programme activities. He therefore proposed that the extension of his borrowing authority be confined to borrowing funds from governments, banks and other external sources. The Committee noted that similar arrangements already existed in several other organizations in the United Nations system, as illustrated in the Director-General's report. As to the amounts to be borrowed, the Committee also noted that this would depend on the magnitude of the shortfall in the payment of contributions, as well as the amounts of internal borrowing which, after the exhaustion of the Working Capital Fund, would be possible in accordance with the above-mentioned provisions of Financial Regulation 5.1.

5. In the light of its examination of this matter, the Committee decided to endorse the proposal for an extended borrowing authority as outlined in the Director-General's report.

6. In the course of its meeting the Committee was informed of the most recent developments in the United States Congress concerning the efforts to repeal the earlier legislation containing restrictive language relating to the utilization of assessed contributions to the United Nations and its specialized agencies, and to the restoration of the amounts previously deleted from those contributions. As it appeared that further information on the likely outcome of these efforts would be available during the present Health Assembly, the Committee decided to recommend that its report on this matter be considered by the Health Assembly as late in its session as may be feasible and practical.

Appendix

REPORT BY THE DIRECTOR-GENERAL TO THE COMMITTEE OF THE EXECUTIVE BOARD

/EB63/CFI/3 - 4 May 1979/

1. When the Executive Board at its sixty-third session in January 1979 considered the supplementary budgetary requirements for 1979 resulting from the decline in the value of the US dollar in relation to the Swiss franc, it was also informed of the possibility of the occurrence in 1979 of substantial delays or shortfalls in the payment of assessed contributions to the WHO regular budget which could have serious financial implications for the Organization's ability to carry out its activities in accordance with the approved programme budget policy and strategy.[1] Moreover, as the amount of casual income that is earned by the

[1] See Executive Board, sixty-third session: Resolutions and decisions (document EB63/48), Annex 1, paragraph 4.2.

Organization in a given year depends to a large extent on the timely payment by Members of their assessed contributions to the regular budget for that year, delays and shortfalls in such payments would affect the amount of casual income becoming available in 1979, which might be insufficient to cover the anticipated budgetary shortfall for that year. Such a development was, unfortunately, not considered impossible, as indicated in the Programme Committee's report on monitoring of the implementation of programme budget policy and strategy.[1]

2. As reported to the Board,[2] the Director-General considered that if the risk of such a situation occurring in 1979 should have become apparent by the time of the Thirty-second World Health Assembly in May 1979, he might have to obtain from the Assembly the authority to borrow from Member States, or from other sources, sufficient funds to cover any budgetary shortfall which could not otherwise be met in order to permit the Organization to carry out its programme pending the receipt of assessed contributions. Such authorization would be additional to the authority to borrow "internally" from other cash resources of the Organization pursuant to resolution WHA29.27 and Financial Regulation 5.1. Any loans incurred under the proposed authorization would have to be repaid either on receipt of Members' assessed contributions or through budgetary appropriations in a subsequent financial period. In view of the uncertainties of the Organization's financial situation in the coming months, the Board agreed with the Director-General that the possibility of such an extended borrowing authority should be examined by the Committee of the Executive Board to Consider Certain Financial Matters Prior to the Thirty-second World Health Assembly, in May 1979, in the light of any further developments.

3. Following the session of the Executive Board in January 1979, the Government of the Member State referred to in the report of the Programme Committee took vigorous action with a view to amending earlier legislation and thus permitting the full payment of that Member's assessed contribution to WHO's regular budget as well as the elimination of restrictive language relating to the utilization of the contribution. However, as the final outcome of the legislative process is not yet known and withdrawals from the Working Capital Fund and internal borrowings might prove to be inadequate to maintain the level of activities included in the regular budget pending the receipt of contributions, the Director-General considers it financially prudent and advisable to submit the proposals described below for an external borrowing authority which would enable him to deal with a significant, temporary shortfall in the payment of assessed contributions to the regular budget.

4. In deciding on how to approach this question the Director-General has considered whether the problem is likely to be of a short-term or of a long-term nature. If the problem were to be of a long-term nature certain drastic measures would have to be considered, involving, amongst others, a very substantial reduction in the Organization's programme activities financed from the regular budget. However, in view of the steps being taken which are noted in paragraph 3 above, the Director-General still believes that the problem is of a short-term nature and confined to the financing of the 1979 programme budget only. Under the circumstances, he does not at present propose any new permanent arrangement or change in the Financial Regulations. If at a later date the assumption as to the short-term nature of the financial problem should prove to be incorrect, he would probably have to consult with the executive heads of the other organizations of the United Nations system, who presumably would then be faced with a similar grave financial crisis, and he would report on the matter to the Executive Board at the earliest opportunity, possibly at a special session convened for this purpose.

5. As to the sources from which funds might be borrowed, the Committee will recall that the authority to borrow internally from certain cash resources available to the Organization[3] was

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[1] See Executive Board, sixty-third session: Report on the proposed programme budget for the financial period 1980-1981 (document EB63/49), Appendix 1, paragraphs 59-63.

[2] See Executive Board, sixty-third session: Resolutions and decisions (document EB63/48), Annex 1, paragraph 4.2.

[3] See Attachment 1.

incorporated in Financial Regulation 5.1 by the Twenty-ninth World Health Assembly (1976) in accordance with resolution WHA29.27. At that time, the Director-General concluded that trust funds and other funds required for the financing of programme activities should not be borrowed under the internal borrowing authority. Given the fact that trust funds and funds donated to the Voluntary Fund for Health Promotion are made available to the Organization for activities which generally have been specified by the donors, the Director-General has again come to the conclusion that any extended borrowing authority granted to him should also exclude voluntary funds and trust funds which are to be used to finance programme activities. Accordingly, he proposes that the extension of his borrowing authority be confined to borrowing funds from governments, banks and other external sources. Similar arrangements already exist in several other organizations in the United Nations system, as illustrated in Attachment 2 to this document. The Director-General proposes that the payment of any interest on such external loans should be debited to the Casual Income Account, to which, it will be recalled, interest earned on the Organization's funds is credited. As to the amounts to be borrowed, this would depend on the magnitude of the shortfall in the payment of contributions, as well as on the amounts of internal borrowing which, after the exhaustion of the Working Capital Fund, would be possible and practical in accordance with the above-mentioned provisions of Financial Regulation 5.1. Any external borrowing of funds would be reported to the next session of the Executive Board. The repayment of amounts borrowed would take place as soon as contributions were received and would have priority over the repayment of funds borrowed internally pursuant to Financial Regulations 5.1 and 6.3.

Attachment 1

COMPARISON BETWEEN MONTHLY TOTAL OF FUNDS AVAILABLE FOR TEMPORARY BORROWING IN ACCORDANCE WITH RESOLUTION WHA29.27 AND FINANCIAL REGULATION 5.1 AND AMOUNTS BORROWED UPON DEPLETION OF THE WORKING CAPITAL FUND
(PERIOD: OCTOBER 1976 - FEBRUARY 1979)

Month	Internal funds available for temporary borrowing					Net cash balance of Working Capital Fund	Amounts borrowed upon depletion of the Working Capital Fund
	Prior years' unliquidated obligations	Terminal Payments Account	Holding and Casual Income Accounts	Other accounts[a]	Total		
	US $	US $	US $	US $	US $	US $	US $
1976							
October	5 153 003	13 071 744	5 826 725	5 181 319	29 232 791	9 115 422	-
November	4 948 186	11 824 292	6 158 167	5 688 865	28 619 510	9 137 175	-
December	3 317 472	12 195 792	8 810 600	6 116 042	30 439 906	(3 831 970)	3 831 970
1977							
January	19 725 653[b]	12 241 619	7 047 888	5 373 670	44 388 830	4 266 833	-
February	17 162 635	12 318 271	7 379 916	5 423 030	42 283 852	7 396 261	-
March	14 986 564	12 407 399	7 740 522	5 058 344	40 192 829	7 669 092	-
April	13 477 711	12 358 470	7 974 607	3 662 385	37 473 173	8 251 036	-
May	11 854 143	12 372 683	8 300 966	3 545 563	36 073 355	8 442 324	-
June	10 727 667	12 346 788	8 588 776	3 566 446	35 229 677	8 428 355	-
July	10 149 588	12 278 214	8 792 696	4 062 353	35 282 851	8 573 567	-
August	9 454 284	12 344 357	8 985 767	4 269 535	35 053 943	8 640 582	-
September	8 859 859	12 359 930	9 358 696	4 531 073	35 109 558	8 432 192	-
October	7 719 869	12 439 688	9 858 708	4 495 625	34 513 890	8 478 558	-
November	7 519 694	12 584 618	10 155 975	4 507 757	34 768 044	8 531 957	-
December	4 098 716	12 821 082	13 285 780	6 521 632	36 727 210	(1 443 417)	1 443 417
1978							
January	24 358 940[c]	12 840 159	10 663 780	3 951 096	51 813 975	(727 712)	727 712
February	21 615 040	12 680 419	11 030 596	3 902 951	49 228 706	8 516 431	-
March	18 682 314	12 881 036	11 372 000	3 898 187	46 833 537	8 605 745	-
April	16 487 046	12 769 900	11 726 687	3 722 720	44 706 353	9 325 794	-
May	15 198 729	12 871 663	3 263 299	4 045 000	35 378 691	9 591 292	-
June	13 502 116	13 023 766	3 358 585	4 720 308	34 604 775	9 833 071	-
July	11 715 607	13 127 434	4 138 450	4 824 405	33 805 896	9 834 981	-
August	10 546 094	13 238 505	4 936 603	5 539 560	34 260 762	10 361 374	-
September	9 221 075	13 482 993	5 277 844	5 573 379	33 555 291	10 428 670	-
October	7 948 388	13 610 849	5 435 145	6 102 109	33 096 491	10 434 158	-
November	6 587 211	13 712 281	5 649 214	5 915 252	31 863 958	10 543 398	-
December	3 834 106	14 145 763	9 945 135	4 647 609	32 572 613	4 161 598	-
1979							
January	28 104 319[d]	14 348 510	9 863 742	4 659 896	56 976 467	2 321 459	-
February	25 640 528	14 482 733	10 722 964	4 665 857	55 512 082	4 735 355	-

[a] Other accounts: Executive Board Special Fund; Real Estate Fund; Revolving Sales Fund; Special Account for Operation of Concessions at Headquarters; Special Account for Servicing Costs.

[b] Including remaining 1976 unliquidated obligations.

[c] Including remaining 1977 unliquidated obligations.

[d] Including remaining 1978 unliquidated obligations.

Attachment 2

BORROWING AUTHORITY IN OTHER ORGANIZATIONS
OF THE UNITED NATIONS SYSTEM

International Labour Organisation (ILO)

ILO's Financial Regulations include provision for borrowing authority under which the Director-General may contract for external loans when the Working Capital Fund as a whole is temporarily inadequate to finance budgetary expenditures pending receipt of contributions. The relevant Financial Regulation reads as follows:

> "Should the Working Capital Fund as a whole be temporarily inadequate to finance budgetary expenditure pending receipt of contributions and/or expenditure incurred in the financing of contingencies and emergencies under prior authorization of the Governing Body, the Director-General may contract loans or advances for such sums as may be necessary pending the receipt of contributions. The amounts borrowed shall be reimbursed as soon as possible from the subsequent receipts of contributions or other income. Such borrowings shall be reported to the Governing Body at the session following the contracting of a loan or advance".

In order to meet the payroll and cover year-end shortages, ILO - after exhausting its Working Capital Fund and various internal borrowing facilities - in December 1978 for the first time secured external loans from commercial banks.

United Nations Educational, Scientific and Cultural Organization (UNESCO)

UNESCO has no provision in its Financial Regulations concerning borrowing authority. However, beginning in 1975 and up to the present time the General Conference has authorized the Director-General specifically to contract for loans to help finance a particular biennial regular programme budget, the most recent one being the 1979-1980 budget. The relevant resolution reads as follows:

> "The General Conference,
>
> Having examined the report of the Director-General on the collection of contributions and advances to the Working Capital Fund (20 C/49),
>
> 1. Expresses its gratitude to Member States which have speeded up the payment of their contributions and to those which, in response to the Director-General's appeal, have granted interest-free loans to the Organization to cover, on a temporary basis, part of its cash requirements;
>
> 2. Expresses to the Director-General its appreciation of the approaches which he is continuing to make to Member States with a view to improving the cash position;
>
> 3. Declares that the non-payment of contributions is a violation of the obligations devolving upon Member States under the Constitution and the Financial Regulations of the Organization;
>
> 4. Urgently appeals to those Member States that are behind with their contributions to pay their arrears without delay;
>
> 5. Calls upon all Member States to take the necessary steps to ensure that their contributions are paid in full at as early a date as possible during the financial period 1979-1980;

6. Authorizes the Director-General, when it becomes necessary, to negotiate and contract short-term loans with lenders of his choice to enable the Organization to meet its financial commitments during 1979-1980 should the anticipated treasury situation of the Organization so dictate".

Up to the present time the Director-General of UNESCO has resorted to external borrowing on two occasions, during the 1976-1977 period. In one case interest-free loans were obtained from certain Member States; in another a loan was obtained from a commercial bank.

Food and Agriculture Organization of the United Nations (FAO)

FAO has no provision in its Financial Regulations for borrowing authority. However, in 1965 and 1966 the FAO Council authorized the Director-General to negotiate and contract loans. This authority was not utilized, and up to the present time it has proved unnecessary for the Council to grant it again.

ANNEX 2

FORMULATING STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000
GUIDING PRINCIPLES AND ESSENTIAL ISSUES[1]

/A32/8 - 15 February 1979/

Document of the Executive Board

I. INTRODUCTION

1. The health status of hundreds of millions of people in the world today is unacceptable. More than half the population of the world does not have the benefit of adequate health care. There is a wide gap between the developed and developing countries in their levels of health and in the resources they are devoting to the improvement of health. Moreover, within individual countries, whatever their level of development, analogous gaps are commonly evident between different groups of the population.

2. The Constitution of WHO and numerous Health Assembly resolutions have reaffirmed that health is a basic human right and a worldwide social goal; that it is essential to the satisfaction of basic human needs and the quality of life; and that it is to be attained by all people. In 1977 the Thirtieth World Health Assembly decided, in resolution WHA30.43, that the main social target of governments and WHO in the coming decades should be "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life".

3. The Declaration of Alma-Ata, adopted on 12 September 1978 by the International Conference on Primary Health Care, which was jointly sponsored and organized by WHO and UNICEF, clearly stated that primary health care is the key to attaining the target of health for all by the year 2000 as part of overall development and in the spirit of social justice. The Declaration called on all governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. The Declaration also called for urgent and effective international - in addition to national - action to develop and implement primary health care throughout the world, and particularly in developing countries.

4. In January 1979, in resolution EB63.R21,[2] the Executive Board of WHO endorsed the report of the International Conference on Primary Health Care, including the Declaration of Alma-Ata, and suggested to the Thirty-second World Health Assembly that it invite Member States to consider using the present document individually as a basis for formulating national policies, strategies and plans of action, and collectively as a basis for formulating regional and global strategies for attaining an acceptable level of health for all by the year 2000.

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[1] See resolution WHA32.30.

[2] Executive Board, sixty-third session: Resolutions and decisions (document EB63/48), p. 24.

5. Before the Executive Board began to identify the essential issues and define the guiding principles for formulating strategies for health for all by the year 2000, it reviewed what these strategies were intended to achieve, namely, what was meant by "health for all". Countries might be expected to have a similar general understanding of the meaning of this term as signifying that, with the objective of continually improving the state of health of the total population, every individual should have access to primary health care and through it to all levels of a comprehensive health system. However, "health for all" will also be interpreted differently by each country in the light of its social and economic characteristics, health status and morbidity patterns of its population, and state of development of its health system.

6. In the process of formulating strategies, especially the setting of national targets, some countries may concentrate more on the health status of the population, while others may concentrate more on the provision of health services. Countries will vary greatly in their interpretation of what is an acceptable level of health. In addition, in attempting to provide health for all, widely different approaches could be used, such as providing on the one hand the full range of services required, starting with those in greatest need and progressively reaching the whole population, or on the other hand providing limited services to the total population from the beginning and progressively extending the range of these services.

7. As a result of all the above, it can be difficult to specify at this stage well-defined objectives and targets and incorporate them into national policies, strategies and plans of action; it is even more difficult to formulate regional and global strategies with well-defined objectives and targets. However, in spite of the complexities involved it is important to attempt to specify national, regional and global targets such as those adopted by the Health Assembly when it resolved to provide by 1990 immunization for all the children of the world against the main infectious diseases,[1] and safe drinking-water and sanitation for the entire world population.[2] It is expected, nevertheless, that agreement on acceptable indicators for assessing progress towards health for all will gradually be evolved.

8. The present document is only the beginning of a long process that will require the unprecedented efforts of all the countries of the world, individually and collectively, over the next two decades. It merely indicates the pathways for attaining the goal of health for all decided by the Health Assembly. One of these pathways is intersectoral collaboration for health development, the importance of which cannot be sufficiently stressed. Health development not only relies on social and economic development, but makes significant contributions to it. When the strategies have been formulated they will constitute an important contribution of the health sector to the new International Development Strategy of the United Nations.

9. It is clear that health for all is to be attained within countries; however, international collaboration and support will be needed to meet this worldwide social goal. In view of this, and in keeping with the policy of basing international action on countries' real needs, it is proposed that strategies should be formulated first and foremost by countries themselves. Regional and global strategies would then be developed collectively on the basis and in support of national strategies and plans of action. It is realized that national policies, strategies and plans of action and regional strategies will vary widely in accordance with the aspirations and capabilities of countries. At the same time, if the goal is to be attained by all the countries of the world, acting collectively as well as individually, there is a need for a common framework for them to formulate strategies and plans of action. The present document is intended to be such a flexible common framework.

10. WHO, in fulfilment of its constitutional function as the coordinating authority on international health work, has an important role to play in the formulation and implementation of strategies for health for all by the year 2000. This role includes promoting worldwide understanding that health for all by the year 2000 is feasible, and facilitating the

[1] Resolution WHA31.53.

[2] Resolution WHA30.33.

coordinated development of strategies to reach the target. To this end, WHO will ensure the availability of relevant and valid information, will support technical cooperation among countries, and will provide technical and managerial support to national, regional and global efforts.

II. BASIC PRINCIPLES

11. An acceptable level of health for all by the year 2000 cannot be achieved by the health sector alone. It can only be attained through national political will and the coordinated efforts of the health sector and relevant activities of other social and economic development sectors. Since health development both contributes to and results from social and economic development, health policies ideally should form part of overall development policies, thus reflecting the social and economic goals of the government and the people. In this way strategies for the health and social and economic sectors will be mutually supportive, and together contribute to the ultimate goals of the society.

12. The Declaration of Alma-Ata and various doctrines that have been built up by Member States through their World Health Organization and other international agencies embody a number of fundamental principles for health development. Among these are: the responsibility of governments for the health of their people; the right and duty of people individually and collectively to participate in the development of their health: the duty of governments and the health professions to provide the public with relevant information on health matters so that people can assume greater responsibility for their own health; individual, community and national self-determination and self-reliance in health matters; the interdependence of individuals, communities and countries based on their common concern for health; more equitable distribution of health resources within and among countries, including their preferential allocation to those in greatest social need so that the health system adequately covers all the population; emphasis on preventive measures well integrated with curative, rehabilitative and environmental measures; the pursuit of relevant biomedical and health services research and the speedy application of research findings; the application of appropriate technology through well-defined health programmes integrated into a country-wide health system, based on primary health care and incorporating the above concepts; the social orientation of health workers of all categories to serve people and their technical training to provide people with the services planned for them.

13. Primary health care forms an integral part of the country's health system, of which it is the central function and main agent for delivering health care. It is also an integral part of the overall social and economic development of the community. For these reasons, the concepts of primary health care, as decided in Alma-Ata, should be the driving force behind the determination of policies and should be kept in mind when formulating strategies and plans of action. For primary health care to succeed, it will require the support of the rest of the health system and of other social and economic sectors concerned. Health system support includes facilities for consultation on health problems, referral of patients to local and more specialized health institutions, provision of supportive supervision and guidance, logistic support, and supplies. As for the other sectors, particular emphasis will have to be laid on such sectors as education, agriculture, animal husbandry, food, water resources, environmental protection, housing, industry, public works and communications.

14. The Alma-Ata Declaration stated that <u>at least</u> the following should be included in primary health care: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

15. The planning, organization and operation of primary health care is a long-term process and total population coverage by it may have to be achieved in stages. An essential feature is that it should be extended progressively, in both geographical coverage and content, until it covers the entire population with all essential components.

III. FORMULATING NATIONAL POLICIES, STRATEGIES AND PLANS OF ACTION

National health policies, strategies and plans of action

16. National policies, strategies and plans of action form a continuum, and there are no sharp dividing lines between them. It would therefore be unwise to be specific in attempting to define them, but it is useful to indicate what each might entail.

17. A national health policy is an expression of goals for improving the health situation, the priorities among those goals, and the main directions for attaining them. A national strategy, which should be based on the national health policy, includes the broad lines of action required in all sectors involved to give effect to that policy. A national plan of action is a broad intersectoral master plan for attaining the national health goals through implementation of the strategy. It indicates what has to be done, who has to do it, during what time frame, and with what resources. It is a framework leading to more detailed programming, budgeting, implementation and evaluation.

18. What follows is a brief analysis of the main issues involved in formulating national policies, strategies and plans of action. These issues have been presented in such a way as to deal first with general political and social matters, then with various processes and mechanisms that may be required, subsequently with the development of primary health care, and finally with monitoring and evaluation. It is not implied in the least that countries should follow this order. Similarly, it is not implied that countries need necessarily follow the order of first completing the definition of policies, then continuing with the formulation of strategies and only afterwards devising plans of action since, as mentioned above, these form a continuum without sharp dividing lines between them. There are many possible entry points to the whole process. Some countries may already have a health system based on primary health care that needs strengthening, and may wish to start from there. Others may have embarked on country health programming, and may find it useful to develop their strategy by continuing the process. Yet others may find it necessary to take one or a series of political and social measures as their starting point.

19. In all cases, it has to be recognized that the way to health for all is not a simple one, but that, if the various issues involved are dealt with adequately, whatever the entry point, the attainment of this goal within two decades is realistic.

National health policies

20. Each country will have to develop its health policies as part of overall socioeconomic development policies and in the light of its own problems and possibilities, particular circumstances, social and economic structures, and political and administrative mechanisms. Whatever the process, each country has to specify its health goals and priorities following the identification and careful analysis of its health problems and socioeconomic capacity to deal with them. In the light of this analysis it will be able to indicate the main directions for attaining these health goals.

National strategies

21. The strategies should incorporate the systematic identification and use of suitable entry points for fostering health development, ways of ensuring the involvement of other sectors bearing on health, the range of political, social, economic, managerial, and technical factors, as well as obstacles and constraints and ways of dealing with them. The action of sectors such as those mentioned in paragraph 13 above is most important. It is part of the national strategy to identify and make use of all favourable conditions and factors, as well as to recognize constraints and identify existing and potential obstacles that could impede the attainment of national goals. The ways of dealing with the above will depend on their nature.

Political commitment

22. The introduction or strengthening of the development process needed to attain health for all will require unequivocal political commitment to bring about the reforms that are

essential to convert this goal into a reality. This will most likely have to be set in motion by political decisions taken by the government as a whole, and permeating all sectors, at all levels throughout the country, and not merely by the ministry of health or the health sector alone. To achieve this wider political commitment, it will no doubt help to involve actively all levels, sectors and interests in the development of national policies, strategies and plans of action. Mobilizing public opinion can also be effective to overcome obstacles. It may be necessary in some cases to have recourse to firm political measures.

23. National political commitment will be reinforced by technical cooperation among countries and by international political support. The will to cooperate with other countries to attain collective health goals and to provide international support to this end also requires the political commitment of governments. In so doing they will have to be ready to ensure that national health policies are consonant with international health agreements, and to share their experience with others.

Social considerations

24. The overall social goal of health for all has to be broken down into more concrete social policies aimed at improvement of the quality of life and maximum health benefits to all. If the gap between "haves" and "have-nots" is to be reduced within and among countries, there will be a need in most countries to formulate and put into effect concrete measures for more equitable distribution of resources. In many countries this will imply the preferential allocation of health resources to those in greatest social need as an absolute priority, as a step towards attaining total population coverage.

25. Sound health policies contribute to overall socioeconomic policies; thus, if the country's overall development policy gives priority, for example, to rural development, urbanization, or industrialization, the health policy has to give preferential attention to these priorities.

Community participation

26. Measures have to be taken to ensure free and enlightened community participation, so that notwithstanding the overall responsibility of governments for the health of their people, individuals, families and communities assume greater responsibility for their own health and welfare, including self-care. This participation is not only desirable, it is a social, economic and technical necessity. Governments will therefore have to devise appropriate ways of promoting such participation, supporting it, effectively propagating relevant information, and establishing or strengthening the necessary mechanisms. Governments, institutions, members of the health professions, as well as all agencies involved in health and development, will therefore have to take measures to enlighten the public in health matters so as to ensure that people can participate individually and collectively, as part of their right and duty, in the planning, implementation and control of activities for their health and related social development. In developing its strategy for this, each country will have to take into account its cultural and social patterns and its political system. As part of community participation, in the process of formulating national health policies, it may help to involve political, social and community leaders, organizations, industry, labour, relevant professions, and those engaged in the mass information media in appropriate local, district and national activities.

Administrative reform

27. The strengthening and adaptation of administrative structures and systems at all levels and in all sectors, not only the health sector, may be required. Intersectoral coordination between health and some or all of such other sectors as education, agriculture, food, water resources, housing and environmental protection is important. A lead has to be taken to ensure this coordination, and whether this devolves upon one of the sectors or on a higher level of government will depend on the country concerned. To achieve such coordination, countries may wish to review their administrative systems to ensure that coordination can take place at central, intermediate and local levels. As part of this review, they may wish to assess the degree to which they need to strengthen local and intermediate levels of the

national administration, by means of delegation of responsibility and authority to the community and to intermediate levels as appropriate, and by the provision of sufficient manpower and resources. In some countries it may be necessary to provide incentives to manpower for service at the peripheral levels, especially in remote and neglected areas.

Financial implications

28. In most countries there will be a need to reallocate resources. In addition, in many countries it will be necessary to increase the national health budget to the greatest possible extent in order to provide the population with essential health care. Maximum use will have to be made of local energy, materials and resources, with the government in the final analysis having to ensure that they are adequate for the health development programme agreed upon.

29. Although most of the resources for national health development come from the country concerned, there will nevertheless be a need for substantial and continuing international support for developing countries. The nature of this support must be subject to decisions of the government of the developing country concerned.

30. It is essential to consider the costs of programmes and services and how they can be borne. These might include government direct and indirect financing, social security and health insurance schemes, local community solutions and the use of external loans and grants. While each country evolves its own methods of financing health and health care services in the light of its circumstances, it is also useful to study the experience, successes and failures of others.

Enabling legislation

31. In some countries it may be necessary to legislate in order to introduce the necessary reforms. In preparing their own legislation, countries may find it useful to consult relevant legislation of other countries compiled and analysed by WHO. Legislative action may have to be accompanied by appropriate mobilization of public support, through information media and other forms of communication with the public. These combined actions may be used to help to define rights and obligations; to protect persons and the environment; and to permit communities to plan, manage and control their health and related social programmes and services.

National plans of action

32. What has to be done. The national plan of action has to specify the policies to be followed, the objectives to be attained and related targets, quantified to the extent possible. It includes the political, social, economic and administrative dispositions and the technology required, together with any necessary legislation and managerial mechanisms and processes. It identifies priority problems and country-wide programmes that have to be formulated in response to them, as well as the main agreed actions to be taken by all sectors concerned, including the development of the health services required to deliver programmes. It also indicates the framework for monitoring implementation and evaluating impact.

33. Who has to do it. The ministry of health or equivalent governmental authority is responsible for promoting and sustaining the development of plans of action. To do so effectively, it has to involve all levels of the health system, including all health workers, as well as the other social and economic sectors concerned. The central level should aim at enabling communities to plan their own primary health care activities in accordance with local needs and circumstances within the framework of the broad national master plan. It should also aim at enabling intermediate levels to support primary health care. To these ends, countries may have to delegate responsibility and authority to community and intermediate levels as part of the administrative reforms mentioned in paragraph 27 above.

34. Time frame. The implementation of plans of action is a long-term process for which it is difficult to specify a definitive, precise timetable in advance. Nevertheless, it is useful to prepare tentative, rough timetables and to refine them progressively, realizing

that implementation will depend on a variety of political, social, economic, managerial and technical circumstances, including the extent to which resources can be made available in accordance with requirements. It is sometimes wise to adopt short-term measures if the initiation of long-term action would lead to too long a delay. This is acceptable however only if the short-term measures are consistent with the main directions foreseen for the long-term action, contribute to the attainment of the national health strategy, and in no way constrain the future implementation of the national plan of action.

35. Resources. Broad allocations and ways of financing have to be defined at the initial stages of formulation of plans of action. Without this, plans cannot be materialized. The nature of the resources and ways of financing them have been referred to in paragraphs 28-30 above. Plans of action have to take into consideration resources actually and potentially available, as well as the progressive increase of resources which will be necessary as the plan evolves. Local, national and international resources have to be taken into account in the proper combination, and attention must be given to the most rational use of these resources, whatever their source. The allocation of resources will have to become progressively more specific as the plans of action are refined.

What the action plan leads to

36. The master plan of action described above leads in turn to the detailed formulation of country-wide programmes that have been identified as being required to deal with priority problems, and to the design of improved health systems to deliver those programmes. The programmes have to be delivered by all levels of the health system, including the support of other sectors. These systems should be based on the primary health care approach.

Programmes

37. A programme implies a series of interrelated actions aimed at attaining defined objectives, such as the improvement of child health or the provision of safe drinking-water to a population. Programmes will vary according to the socioeconomic and epidemiological situation in each country. Each country-wide programme to be developed in the light of the master plan will include specific objectives and related targets, quantified if possible, and including the manpower, technology, physical facilities, equipment and supplies required, means of evaluation and financial estimates, a calendar of action, and ways of ensuring appropriate correlation among all the above.

Health system design

38. A health system is composed of various levels, the first of which is the point of contact between individuals and the system, where primary health care is delivered. The various intermediate levels as well as the central level provide support, and specialized services which become more complex as they become more central.

39. The design of a health system of which primary health care is the central function and main delivery agent involves identifying those components of the health sector and other interacting sectors required to deliver health programmes at the various operational levels. The functions of these components are then defined. The services and institutions required at different levels to fulfil those functions are specified. The necessary interaction between services, institutions and people at each of these levels is also indicated.

Processes and mechanisms

40. To facilitate the formulation and implementation of national policies, strategies and plans of action, countries may find it useful to introduce, rationalize or strengthen their health planning processes, and use a variety of mechanisms to this end.

Country health programming

41. A health planning process which has demonstrated its usefulness in recent years is known as country health programming. Country health programming is much more than a methodology:

it is a systematic, continuing national planning and programming process. It includes policy formulation and the definition of priorities. It involves the preparation of programmes to give effect to these priorities, the preferential allocation of budgets to them, and the integration of the different programmes within the overall health system. It also deals with the monitoring and evaluation of strategies and plans of action, as well as programmes and the services and institutions for delivering them, with a view to modifying existing plans or preparing new ones as required, as part of a continuing cycle.

42. Most countries are dealing with all these aspects of planning, but not always in a systematic and interrelated manner. The initiation of a more systematic process may start with any of the above-mentioned steps, subsequently leading to the remaining steps being carried out in a systematic and interrelated manner. Thus, there could be many possible entry points to the country health programming process. Countries may find it useful to refer to the WHO Guidelines for Country Health Programming.[1]

Evaluation process

43. As mentioned in paragraph 41 above, the evaluation process is part of the national health planning process. It consists of monitoring the implementation of the policies, strategies and plans of action, and of assessing their impact in terms of the improvement of the health status of the population.

National health information system

44. In order to facilitate national health planning and evaluation as well as the implementation of the policies, strategies and plans of action, governments may find it useful to develop or strengthen their national health information systems so as to ensure the timely availability of the right kind of information, keeping its collection to the useful minimum. Information systems will vary in complexity in different countries. In all cases they should fulfil the specific needs of the country within its economic means and, as far as possible, should be internationally compatible.[2]

Training in health management

45. Appropriate training in health planning and management at all levels is urgently needed to prepare and sustain the capabilities of the manpower required to formulate and implement the national policies, strategies and plans of action. A review of such training is mandatory because of the inappropriateness of much of it for present needs. The Executive Board of WHO is embarking on a study of this matter. The results of the study and the Board's recommendations will add to present knowledge of training processes. It can already be stated that a useful mechanism envisaged is the establishment or strengthening of national centres for health development as mentioned in paragraph 49 below.

Ministries of health

46. As mentioned in paragraph 33, ministries of health or equivalent governmental authorities have a central role in defining national health policy, in ensuring the preparation of strategies and plans of action to give effect to it, and in the subsequent formulation of health programmes, and the design, operation and control of health systems. To be effective, they have to be an integral part of the mainstream of policy decision-making at the highest governmental levels, and to ensure the continuing involvement of ministries of finance, planning or similar bodies and other ministries and authorities dealing with socioeconomic

[1] A revised version of these guidelines is in preparation.

[2] Technical discussions on health information systems have been held in conjunction with the Regional Committees for Europe and South-East Asia and a further consultative meeting has taken place in the South-East Asia Region. During 1979 meetings will be organized in the Regions of the Americas and the Western Pacific, and an interregional meeting will be held in Costa Rica, in order to develop globally applicable principles and guidelines.

development. In many countries this implies the need to strengthen them with respect to their political, social, technical and managerial functions, so that they are fully capable of ensuring coordination within the health sector, maintaining dialogue with other sectors, and participating in overall national socioeconomic development.

47. Experience has shown the need to create or strengthen within ministries of health a permanent coordinating mechanism at the highest level so that the ministry can fulfil the responsibilities and functions indicated in paragraph 46. Technical planning units may be useful to support such a high-level coordinating mechanism but can never act as a substitute for it. It is important to ensure that all technical and administrative units in the ministry gear themselves to their new role. In addition to the types of staff normally employed in ministries of health, it may be necessary to draw on expertise in such other fields as the economic, political and social sciences.

National health councils

48. Governments, in fulfilment of their important function of mobilizing professional and public support for, and participation in, the development and control of the new policies, strategies and plans of action, may find it useful to establish or strengthen national health councils. The constitutional position of these councils has to be made as clear as possible. They would normally be of an advisory nature, being accountable in some countries to the ministry of health and in others to the highest executive or legislative authorities. Such councils could be particularly valuable in ensuring that health systems are developed as an integral part of overall social and economic development. National health councils might therefore be composed of personalities representing a wide range of interests in the fields of health and political, economic and social affairs, as well as the population at large, including the rural population. In this context the whole range of policy questions affecting health and socioeconomic development could be explored jointly, thus sensitizing health leaders to social and economic realities, social and economic representatives to health realities, and all of them to the realities of health service consumers. It might be useful also to create such councils at other levels, depending on the size and political administrative system of the country.

National centres for health development

49. It is suggested that ministries of health consider establishing or strengthening one or more national centres for health development. These centres would deal with the development of the country health programming process, the investigation and clarification of management aspects concerning the development of primary health care, and the related health services research. To fulfil these functions, they will work in close collaboration with all social and economic sectors concerned. The location, structure, and institutional affiliation of these centres will vary from country to country. In all cases, however, they should be functionally related to the highest health authorities, preferably servicing national health councils. They would also serve as advisory, training and information centres, and in this way would help to build up cadres of adequately trained health manpower in the areas mentioned above. Some of these centres could be placed at the disposal of other countries as sub-regional or regional centres, as mentioned in paragraph 83 below.

Primary health care

Basis for health development action

50. Since primary health care is the key to attaining an acceptable level of health for all, its planning, organization and efficient operation are basic for implementing national plans of action. The Declaration of Alma-Ata states that "the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world". It is therefore suggested that it be used as a companion to the present document. What follows is a summary of the main points to be taken into account when developing primary health care as part of the national plans of action. The

page numbers in parentheses refer to the report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 (the Alma-Ata report).[1]

Essential health programmes and services

51. It is necessary to decide on the programmes which primary health care has to deliver, and in consequence on the services that have to be provided. The minimum content of primary health care as defined in the Declaration of Alma-Ata appears in paragraph 14 above.

Communities, support and coverage

52. It is necessary to define, on the basis of agreed criteria, the size and types of communities for front-line primary health care as well as their grouping for purposes of support and referral. In so doing attention has to be paid to population coverage and the accessibility of health care (Alma-Ata report, pages 16-18, 26, 31 and 58-59). Ensuring community participation has been dealt with in paragraph 26 above, and further details can be found in the Alma-Ata report (pages 16-18, 23, 25 and 49-52).

Appropriate technology for health

53. When considering health technology in the course of devising strategies, formulating programmes, and designing services to deliver them, governments may find it of value to review existing technologies, identifying those that are appropriate, and to indicate and promote the type of research required to develop alternatives to inappropriate technologies. In so doing, governments may find it useful to promote the participation not only of governmental departments concerned, but also of research and academic institutions, industry, and nongovernmental organizations, both in the health sector and in associated sectors. Proper involvement of the community will help to assess the appropriateness of the technology. This is a major area in which technical cooperation amongst countries is vital (Alma-Ata report, pages 19, 27-28 and 57-61).

Health manpower development and training

54. In view of the crucial role of human resources, most governments will no doubt wish to take vigorous action to ensure the availability of adequate numbers of the appropriate types of health personnel required to devise and implement the plan of action. This will involve the reorientation of existing health workers as necessary, development of new categories of workers in health and related sectors, and motivation and training of all manpower to serve the community. The useful role of traditional medical practitioners and birth attendants in many societies will need to be taken fully into account where applicable. Similarly, consideration should be given to the use of voluntary health workers. In order to ensure the social orientation of health workers of all categories to serve people, and to train them technically to provide the services planned for them, governments will no doubt wish to ensure the cooperation of ministries of health and education and all relevant educational and training institutions. This may call for reform of educational programmes where appropriate. The role of family members will also need to be considered when dealing with health manpower, particularly with respect to self-care as part of primary health care, i.e. the assumption of responsibility by individuals and families for their own health care (Alma-Ata report, pages 18-19, 25-27 and 61-64).

Referral process

55. To ensure an adequate two-way support and referral process, a system needs to be devised that links the various institutions involved, starting from individuals and the simplest of health institutions in small communities and continuing through increasingly complex institutions along the health system chain. Particular attention has to be paid to those institutions which provide direct support to primary health care. It is thus especially useful to review the functions, staffing, planning, design, equipment, organization and management of health centres and district hospitals, in order to prepare them for their wider function in support of primary health care (Alma-Ata report, pages 18-19, 23, 25, 28 and 64-66).

[1] Alma-Ata 1978: Primary health care. Geneva, World Health Organization, 1978.

Facilities, logistic support and control

56. When dealing with the types of physical facilities required at each of the levels, the costs of their maintenance no less than of their construction have to be borne in mind (Alma-Ata report, pages 19, 28 and 67). The kinds of equipment and supplies, including essential drugs, have to be decided upon. A proper logistic system has to be developed to ensure the timely provision and maintenance of supplies and equipment (Alma-Ata report, pages 19, 28 and 66). A system of control of primary health care with its supporting services has to be introduced (Alma-Ata report, pages 19, 29 and 69).

Health research

57. National health research capabilities may have to be strengthened, and this can best be achieved by involvement in the planning and carrying out of relevant research activities. Biomedical and health services research will have to be oriented towards dealing with problems relating to the formulation and implementation of national policies, strategies and plans of action. This might include intersectoral research, for which relationships would have to be established with the institutions concerned in the other sectors. Biomedical research may be required to elucidate outstanding health problems and to develop new or better ways of dealing with them. Health services research may be required for the design of health services that ensure efficient and effective delivery of health programmes, and for the development and application of appropriate technology. Governments have a responsibility to ensure that the research required is a natural component of the health programme to which it relates, and that health managers are also involved in its conduct as appropriate. They may find it necessary to create specific mechanisms to coordinate research activities, such as national health research councils, which exist in some countries and whose establishment should be extended to others. In so doing they will no doubt find it useful to link these mechanisms to the regional and global mechanisms for research promotion and coordination referred to in paragraphs 84 and 101 below.

Reorientation of the existing health system

58. It is particularly important to ensure that the health system as a whole evolves in accordance with the direction and content of the new policies, strategies and plans of action, and that primary health care and its support do not become a parallel system that is a "poor relation" of the existing system. In ensuring adequate support to primary health care at all levels, governments will no doubt have to face the realities of the existing health system, whose functions and emphases may differ greatly from those required to implement the new policies, strategies and plans of action. Governments may have to review the ways in which programmes are being delivered, services organized, institutions operated and coordinated, and resources and energies expended. The aim of this review should be to coordinate efforts in order to give effect to the new policy (Alma-Ata report, pages 18-20, 23-25 and 39-40).

Support of other sectors

59. Similarly, in ensuring the support of other sectors to primary health care, governments may have to review existing mechanisms and channels of communication between the sectors, also taking into account general administration and finance. This should lead to specific and workable arrangements at all levels for the coordination of health services with other activities contributing to health promotion through primary health care (Alma-Ata report, pages 17, 20, 23-24, 27-30 and 46-49).

Guidelines required

60. Guidelines have to be provided to help communities plan and organize their primary health care services. These should include ways of deciding on local mechanisms for planning, operating and controlling the implementation of activities; the composition, authority and responsibility of these mechanisms; and ways of establishing the effective relationships between the health and other sectors in the community, and of ensuring that the voice of the whole community is heard. These guidelines also have to provide information on such issues

related to primary health care as appropriate technology, community health workers and their training, equipment and supplies, physical facilities, and methods of control. They should also indicate how to establish clear-cut procedures that will be known to the community as a whole and to the health workers, and that can be followed by them. Countries may find it useful to call on WHO to prepare draft guidelines for this purpose, it being understood that these will require adaptation to national and local circumstances.

Monitoring and evaluation

61. To permit governments to know whether they are making progress toward attaining an acceptable level of health for all their people, it is important that they introduce at the earliest stages a process of evaluation. This will include the assessment of the effectiveness and impact of the measures they are taking, and the monitoring of the progress and efficiency with which these measures are being carried out.

62. Monitoring of implementation and evaluation of impact take place at two levels - the policy level and the managerial and technical levels - but the two have to be interlinked. At the policy level there is a need to know if the health status of the population is improving and if revisions of the policy, strategy and plans of action are required. At the managerial and technical levels there is a need to know if relevant programmes are being properly formulated and if corresponding services and activities for implementing them are being adequately designed. There is also a need to know if programmes are being efficiently implemented through suitably operated health and related social and economic services.

63. There is thus a need for two types of indicators - those that measure the health status and related quality of life, and those that measure the provision of health care. In both cases, high selectivity has to be employed so that the use of indicators becomes manageable and meaningful. Two basic health indicators concerned with survival that are suggested for measuring the attainment of the ultimate goal of an acceptable level of health for all are life expectancy at birth and infant mortality rate. Each country will decide on its own norms, but a minimum life expectancy of 60 years or more at birth, and a maximum infant mortality rate of 50 per 1000 live births, are suggested as indicating that the health status of the population is becoming a decreasing burden on individual, family and community development. It should be recalled that indicators are not synonymous with targets, but are measures of the extent to which those targets are being reached. All countries, even if the health indicators show that the above norms have been attained, will wish to develop strategies for improving still further the health status of their people, and will consequently wish to define targets to this end. It should also be noted that indicators of survival become less relevant as countries develop socially and economically.

64. Other indicators measure not only survival but also the quality of life. This implies that social as well as health indicators have to be used. Examples of these are indicators of growth and development, indicators of nutritional status, and specific morbidity rates, particularly in children. Other indicators relate to social conditions and factors that affect health status directly or indirectly, or the use of health services - for example, indicators of educational and cultural levels, of the status of women, of housing and of environmental conditions. Yet other indicators relate to psychosocial factors and mental health aspects of the quality of life. A number of relevant social indicators remain to be developed, such as those for assessing the degree of community self-determination, social and economic productivity, and the closure of gaps in the distribution of health resources. To arrive at these, there is a need to make use of intersectoral research.

65. In monitoring implementation through the provision of health care, it is important to use as reference points those objectives and targets that have been set as part of the process of formulating programmes and designing the health system. It is particularly important to monitor whether priorities are being adhered to, realizing that these may have to be implemented progressively. Indicators are then selected that can measure change toward attaining the objectives and reaching the corresponding intermediate and final targets, for example: the percentage of the population having safe drinking-water and waste disposal systems; the rates for women attended by suitably trained health workers during pregnancy and childbirth; and the

percentage of children immunized against the common infectious diseases. It will be necessary to develop locally suitable indicators of coverage and accessibility of services as a measure of the provision of health care.

66. Whatever the indicators selected, they have to be closely related to the means available for data collection and processing, including lay reporting, and should be gathered as an intrinsic part of the system for delivering health care. Sampling often suffices, and has the advantage of avoiding overloading health workers with routine data collection, which often leads to inaccurate reporting and unused information. Such sampling should take into account all strata of the population and other factors as appropriate to the country concerned, in order to reveal country-wide variations in addition to the national average.

67. To monitor progress and evaluate the efficiency, effectiveness and impact of the policies, strategies and plans of action, countries may find it helpful to make use of the WHO Guidelines for Health Programme Evaluation (document HPC/DPE/78.1).

Role of WHO

68. The role of WHO in promoting and supporting the formulation and implementation of national strategies and plans of action is covered in paragraphs 118-119 below.

IV. FORMULATING REGIONAL STRATEGIES

Regional strategies

69. Regional strategies are arrived at through the collective decision of the countries in each region. They will involve the adoption or strengthening of regional health policies, and the stimulation of relevant regional bodies, such as the regional economic commissions, to adopt related social and economic policies. These policies should include the health and related socioeconomic goals for the region. Use could be made of current long-term health plans, including regional health charters and subregional agreements where they exist. The need for collaboration among neighbouring countries belonging to different WHO regions should not be forgotten. Regional strategies should foster the development and implementation of national policies, strategies and plans of action, and support countries in preparing and implementing them. For this purpose, regional strategies should be developed without delay and should include tentative rough timetables that can be progressively refined.

70. Regional strategies should be designed to give effect to regional health and related socioeconomic policies. They should embrace a synthesis of national policies, strategies and plans of action as seen from a regional perspective, and should indicate priority issues for international action within the region, as well as the broad lines for such action, in health and other sectors concerned, that have to be undertaken by the countries of the region individually and collectively.

71. The strategies should include well-defined objectives and related targets, quantified to the extent possible, for the region as a whole. They should also include the establishment or strengthening of intercountry and regional processes, mechanisms and arrangements to support national action. They should propose the means of evaluating progress towards attaining an acceptable level of health in the region, and should identify the implications of the regional strategies for the global strategy.

72. The paragraphs that follow illustrate the various components of regional strategies and issues which have to be considered when formulating them.

Regional promotion and support

73. Regional strategies should include the promotion of the idea that an acceptable level of health for all by the year 2000 is feasible. They should stimulate international support for activities aimed at attaining this goal. To this end, use should be made of WHO and in particular of its regional committees, of other regional political fora within and outside the health sector, and of regional and subregional groupings of countries.

74. Regional strategies should envisage the strengthening of regional mechanisms to attract bilateral and multilateral funds and ensure that they are channelled into priority activities in countries. For this purpose, estimates should be made of the orders of magnitude of the total resources required for health development in the region, including those required for transfer between countries and regions.

75. To foster intersectoral support, efforts should be made to establish or strengthen appropriate political, economic and technical relationships with the regional economic commissions of the United Nations as well as with relevant regional social and economic organizations and the regional bureaux of global social and economic organizations, both within and outside the United Nations system, such as the United Nations Development Programme. Full use should be made of the resources of the regional economic commissions, particularly those required for intersectoral collaboration.

Overcoming obstacles

76. Regional strategies should include ways of helping countries to overcome obstacles. One of the best ways of overcoming such obstacles as political indifference in countries to adopting strategies for attaining health for all is to exercise collective regional moral pressure. This might include, in addition to the promotional efforts described in paragraphs 73-75 above, collective action to gain the support of political and social leaders, as well as those engaged in the mass information media, by involving them in appropriate regional activities. In the same way, attempts should be made to mobilize the health professions and other groups interested in health matters. Every attempt should be made to promote the support of the medical and related industries by encouraging them to produce equipment for appropriate technology and to manufacture essential drugs at reasonable cost.

Regional information exchange

77. Relevant and valid information will have to be made available on methods, processes, mechanisms and technology. This should be achieved mainly by the promotion of the exchange of information among countries through live contacts, formal and informal meetings, written communications and publications. Mechanisms will have to be strengthened to ensure not only that the relevant and valid health information is collated, analysed and subsequently disseminated but also that this information can be properly absorbed by those who require to use it.

Technical cooperation among developing countries

78. Technical cooperation implies activities that have a high degree of social relevance for countries in the sense that they are directed towards defined national health goals and that they contribute directly and significantly to the improvement of the health status of their populations through methods that they can apply now and at a cost they can afford now. On no account should the concept be considered as a new name for technical assistance, which has led in most instances to fragmented projects that have had little real influence on the improvement of the national health situation and have not promoted the self-sustaining growth of the relevant programme in the country after the assistance ceased. Technical cooperation implies that no matter at what operational level programme doctrines have been generated or programme activities implemented the programmes have to be concerned with solving specific priority national health problems. The development of technical cooperation programmes implies the identification of needs <u>in</u> countries <u>by</u> these countries as well as the identification or generation of appropriate methods for meeting these needs. These methods have to take full account of the social and economic contexts in which they are to be applied.

79. Technical cooperation among developing countries (TCDC) is an essential aspect of regional strategies. This has been interpreted in the United Nations system to include technical cooperation among developed countries and among developing and developed countries. The mutual support of countries for attaining an acceptable level of health for all their people will consist mainly of the sharing of expertise and training facilities, the development of appropriate technology and the exchange of information and experience, using national institutions.

80. At the regional level, agreements will have to be reached among countries on such matters as drug manufacture and bulk purchase, the selection of countries for vaccine production as part of the drive to reach regional self-reliance in vaccine supply and the selection of firms dealing with low-cost technology, for example for water supply. TCDC could also include the establishment of relationships with regional social and commercial organizations and enterprises with which individual and collective collaboration could be worth while.

81. Regional strategies should include the establishment or strengthening of regional mechanisms for promoting, supporting and coordinating this kind of technical cooperation among countries, making sure that national institutions are properly used for this purpose. This should include the development of an appropriate TCDC information service. Countries should use the regional offices of WHO to ensure the best possible coordination of such regional mechanisms.

82. Regional strategies should make full use of WHO's provisions for technical cooperation with its Member States. This would include making use of the processes and mechanisms developed in WHO by its Member States for national health programme development, as well as specific cooperation for programme development, institution strengthening, and health manpower planning and training, both with individual countries and at intercountry and regional levels.

Regional networks of health development centres

83. Full use will have to be made by groups of countries, or by all the countries of the region, of national research, training and development centres of the types and for the purposes mentioned in paragraph 49 above. These national centres should be linked together in regional networks as part of the implementation of TCDC.

Regional orientation and support for research

84. Regional strategies will have to include measures to ensure that national and intercountry biomedical and health services research activities deal with priority problems whose solution will contribute to the fulfilment of the national and regional strategies and plans of action. Support will have to be given to the strengthening of national health research capabilities through the involvement of countries in the development and conduct of relevant national and intercountry collaborative research, and through the training of health and related workers in relevant research practices and methods. Cooperation among countries in different regions should be facilitated as necessary and due attention paid to global research efforts in the areas concerned. The strategies should also include the planning and carrying out of any intersectoral research required at the regional level, and the establishment of relationships with the regional institutions concerned. Countries should make full use of WHO's regional advisory committees on medical research for the above purposes.

Regional use of national expertise

85. Regional use of national expertise, drawn from different disciplines and sectors, will support the development and operation of the national strategies and plans of action in the areas concerned. Good examples of how national expertise can be used for the benefit of all countries within a given region are the WHO regional advisory committees on medical research. In addition, these committees can be of benefit to countries in other regions since their activities are correlated within the framework of the WHO global Advisory Committee on Medical Research. As another example of how national expertise can be profitably used, it is suggested that regional health development advisory councils should be established. These should be groups of national experts from health and relevant socioeconomic sectors, and should deal with all regional questions of health development as they relate to social and economic development.[1]

[1] Various groups of national experts from health and relevant social and economic sectors have started to function in a number of regions.

86. The Executive Board is currently carrying out an organizational study on "The role of WHO expert advisory panels and committees and collaborating centres in meeting the needs of WHO regarding expert advice and in carrying out technical activities of WHO". The results of this study will have important implications for the use of national expertise in formulating and implementing regional and global strategies.

Global implications of regional strategies

87. The regional strategies should identify those regional policies which could be strengthened by appropriate global policy, and should indicate those aspects of the regional strategy that could benefit from global action and support as part of the global strategy.

Regional monitoring and evaluation

88. A common regional evaluative framework will have to be agreed upon. This should include monitoring the formulation and implementation of the national and regional policies, strategies and plans of action, and evaluating their impact in improving the health status of the people in the region towards attaining an acceptable level. To these ends, a short list of indicators will have to be selected that are applicable for the region as a whole. It will no doubt be necessary to support countries in monitoring and evaluating their strategies and plans of action, as described in paragraphs 61-67 above, and to carry out periodic reviews of regional strategies.

Role of WHO

89. The role of WHO, including the regional offices, in formulating and implementing the regional strategies is outlined in paragraphs 120-124 below.

V. FORMULATING THE GLOBAL STRATEGY

Global strategy

90. The global strategy is arrived at through the collective decision of the countries of the world in the World Health Assembly. It will involve the adoption or strengthening of global health policies and the stimulation of relevant global bodies, such as the United Nations Economic and Social Council and the United Nations Children's Fund, to adopt related social and economic policies. These policies should include the health and related socioeconomic goals of the whole world. The global strategy should foster the development and implementation of regional and national policies, strategies and plans of action, and should support countries, both in regional groupings and individually, as appropriate, in preparing and implementing them. For this purpose, the global strategy should be developed without delay, and should include a tentative rough timetable that can be refined progressively.

91. The global strategy has to give effect to the global policy of health for all by the year 2000. It should embrace a synthesis of regional strategies as seen from a global perspective, and it should indicate priority issues for international action on a worldwide scale, and the broad lines for such action, in health and other sectors concerned, to be undertaken by the countries of the world individually and collectively.

92. The global strategy should include well-defined objectives for the world as a whole and related targets, quantified to the extent possible, though it is realized that this is a complex and difficult task. It should include the establishment of intercountry and interregional processes, mechanisms and arrangements to support global, regional and national action. It should also include the global means of evaluating progress towards the attainment of the goal of health for all by the year 2000.

93. The paragraphs that follow illustrate the various components of a global strategy and issues which have to be considered when formulating it.

Global promotion and support

94. The global strategy should include the promotion, at the highest governmental and non-governmental international levels, of the idea that an acceptable level of health for all by the year 2000 is feasible. It should serve to stimulate international interest in and support for this idea throughout the world. To this end, use should be made of all appropriate global fora. Maximum use will have to be made of WHO, notably through the Health Assembly and the Executive Board, as well as of other global fora both within and outside the health sector, such as the United Nations, its Economic and Social Council, UNDP, UNICEF and the specialized agencies. The Alma-Ata report and the present document should be brought to the attention of the Economic and Social Council and the United Nations General Assembly at an appropriate time.

95. The global strategy should envisage the strengthening of global mechanisms, such as the establishment of an appropriate body of participating countries[1] for attracting bilateral and multilateral funds and for ensuring that they are channelled into priority activities in countries. For this purpose, estimates should be made of the orders of magnitude of the total resources required for health development in the world, including those required for transfer between countries and regions.

96. To foster intersectoral support, efforts should be made to establish or strengthen appropriate political, economic and technical relationships with the United Nations, its relevant services, organs, programmes and specialized agencies. These relationships are especially important with the Economic and Social Council, UNDP, UNFPA, UNICEF and the World Bank, as well as with appropriate global social and economic organizations outside the United Nations system.

Overcoming obstacles

97. The global strategy should include ways of overcoming obstacles of a worldwide nature. This could mean promoting collective action at highest international levels, involving governmental and nongovernmental organizations, to mobilize the health and related professions, generate the active support of worldwide information media, and influence multinational economic groupings and corporations. The strategy should also envisage support to regions in overcoming obstacles that have been identified by them as being more than regional in scope. Collective global moral pressure may have to be exercised.

Global information exchange

98. Relevant and valid information will have to be made available on methods, processes, mechanisms and technology. To ensure that information is both relevant and valid, the global strategy will have to provide for the means and resources to collate, distil, synthesize and validate information so that it will have practical value for countries in solving their health problems. It will also have to ensure the proper distribution of such information to those who need it.

Technical cooperation among developing countries

99. The global strategy should envisage appropriate global support to regional and inter-country actions for technical cooperation among developing countries (TCDC). At the global level, agreements will have to be reached on policies relating to such matters as the production, quality control, pricing, export and import of such commodities as drugs, vaccines, food, prophylactic, diagnostic and therapeutic equipment and supplies. TCDC could also include the establishment of interregional relationships among social and economic organizations and enterprises whose activities have worldwide implications for health.

100. The global strategy should include the establishment or strengthening of global mechanisms for ensuring the development and coordination of TCDC activities among regions, together with the exchange of TCDC information between countries. It should also include

[1] For example, a body of the type mentioned at a meeting of representatives of these countries held at WHO headquarters in November 1978.

support to the development of regional mechanisms, such as the regional networks of health development centres mentioned in paragraph 83 above, and provide for interregional cooperation in this field.

Global orientation and support for research

101. The global strategy will involve a reconsideration of current health research policies with a view to making them supportive of overall health policies. It will have to include measures to ensure the proper orientation of biomedical and health services research so that it can make an effective contribution to the solution of problems which are impeding attainment of an acceptable level of health for all. This will no doubt imply significant modifications to current health research trends and greater involvement of the world scientific community in these endeavours. The global strategy will also include the support of national and regional research efforts. Consideration will also have to be given to the intersectoral research required at the global level and to the establishment or strengthening of relationships with the global institutions concerned, particularly the relevant specialized agencies and institutes of the United Nations. Countries should make full use of WHO's global Advisory Committee on Medical Research for the above purposes.

Global use of national expertise

102. The strategy should include the use of national expertise for dealing with problems on a worldwide scale. For this purpose, countries should use such bodies as WHO's panels of experts and the global Advisory Committee on Medical Research. It is suggested that a global health development advisory council should be established, that is, a group of national experts from health and other relevant socioeconomic sectors to deal with all global questions of health development as they relate to social and economic development. This group would work in close liaison with the regional groups of a similar nature mentioned in paragraph 85.

103. Reference is again made in this context to the Executive Board's organizational study mentioned in paragraph 86 above.

Global monitoring and evaluation

104. A global evaluation framework will have to be agreed upon. This will include monitoring the worldwide efforts and evaluating their impact in attaining health for all by the year 2000. A short list of indicators will have to be selected that are applicable in the global perspective. In addition, guidelines will need to be prepared to support regions and countries in selecting and using health and related socioeconomic indicators for monitoring the implementation of strategies and plans of action and evaluating their impact in improving the health status of the people as described in paragraphs 61-67 above. These guidelines should also include the methods and means required to collect and analyse the information, including reporting by nonprofessional health workers as appropriate.

Role of WHO

105. The role of WHO, including its headquarters, in formulating and implementing the global strategy for health for all by the year 2000 is outlined in the following section, in paragraphs 125-131.

VI. THE ROLE OF WHO

106. According to its Constitution, WHO is an organization of Member States cooperating among themselves and with others to promote and protect the health of all peoples. Such cooperation among Member States makes it possible for WHO to fulfil its constitutional functions of acting as the directing and coordinating authority on international health work and of furnishing appropriate technical cooperation upon the request or acceptance of governments.

107. In carrying out these interrelated and mutually supportive functions, WHO has a central role in developing strategies for attaining an acceptable level of health for all by the year 2000. WHO will fulfil this role through the promotion, coordination and support of the

efforts described in the previous sections, in countries individually and through their collective action at regional and global levels.

Role of WHO in promotion and coordination

108. WHO will be instrumental in promoting worldwide understanding that an acceptable level of health for all by the year 2000 is feasible, and that primary health care is the key to this. WHO will carry out such promotion among policy makers at top government level, and among professional groups in the health and related social and economic sectors. It will also actively promote the idea among the general public. WHO will stimulate the interest and support of other international organizations both within and outside the United Nations system, as well as through international nongovernmental organizations.

109. WHO will use its constitutional organs and regional arrangements to ensure the coordinated development of strategies at all operational levels and will support countries individually and collectively in overcoming obstacles. WHO will establish mechanisms such as that mentioned in paragraph 95 above, through which participating countries will be able to ensure that bilateral and multilateral support is channelled first and foremost into priority activities in countries as determined by them within the framework of their strategies and plans of action, as well as into priority intercountry activities included in regional strategies. In so doing, WHO will ensure that all funds channelled through it are devoted to activities that conform to its policies and priority programmes. WHO will estimate the order of magnitude of resources required as mentioned in paragraphs 74 and 95 above.

Information role of WHO

110. WHO will ensure the availability of relevant and valid information to facilitate the formulation and implementation of policies, strategies and plans of action. To this end, WHO will ensure that information is distilled, analysed, synthesized and properly disseminated among countries. It will also collect relevant information from other sectors involved in social and economic development as well as from the health sector. As part of the strengthening of its information role, WHO will rely on such mechanisms as regional and national centres for health development as these are progressively established and strengthened.

111. WHO will use the opportunity of bringing together policy makers in such bodies as the regional committees and the World Health Assembly, and health managers, practitioners and researchers in various types of meetings, to exchange such information. It will orient further its written communications and publications towards the provision of information required to prepare and implement strategies and plans of action. It will make information available to Member States on the experience of countries in which strategies and plans of action for health for all are being carried out. It will also provide information on relevant national health legislation. Consideration will be given to making "Health for all by the year 2000" the theme of World Health Day in the near future.

Technical cooperation among developing countries

112. WHO will support technical cooperation among developing countries, among developed countries, as well as among developed and developing countries. It will create mechanisms for ensuring timely and appropriate exchanges of information among countries interested in the possibility of technical cooperation among themselves. It will also maintain relationships with other bodies, such as the United Nations regional economic commissions, for this purpose. WHO will maintain proper contacts with the UNDP Information Referral System for Technical Cooperation Among Developing Countries (TCDC/INRES). Whereas the financing of TCDC activities is mainly the responsibility of the countries themselves, WHO will provide for indispensable technical and administrative overhead costs.

113. To facilitate TCDC, WHO will further develop suitable mechanisms at the regional level. In addition to maintaining contact with other sectors and being closely involved in the information service mentioned above, the mechanisms will deal with such matters as commercial questions related to TCDC and legal questions in support of countries which so wish in

reaching agreements and signing contracts. These mechanisms will ensure that all WHO programme activities take into account the possibility of being implemented through TCDC. WHO will support cooperation between national centres for health development, for whose establishment and functioning it will prepare guidelines, and which it will help to organize in regional and interregional networks.

WHO support to country, regional and global efforts

114. WHO will provide technical and managerial support to national, regional and global efforts. It will be particularly active in developing appropriate technology in fields that directly contribute to attaining an acceptable level of health for all.

115. WHO will ensure any further development of appropriate managerial processes required for health development in the manner prescribed by the Health Assembly[1] and for designing health systems based on primary health care. It will ensure that the processes for country health programming, national health programme budgeting and health programme evaluation, as well as for the provision of adequate information support, are developed in a coordinated manner and in such a way as to facilitate the formulation and implementation of national policies, strategies and plans of action. WHO will also ensure that its own processes for programme development, including the general programmes of work, medium-term programming, programme budgeting, health programme evaluation and information systems support, give priority to the essential requirements for the formulation and implementation of the worldwide strategies and plans of action.

116. WHO will play a leading role in orienting biomedical and health services research, through its regional and global advisory committees for medical research, and in supporting research activities aimed at providing solutions required for the formulation and implementation of strategies and plans of action.

Monitoring and evaluation

117. WHO will be instrumental in ensuring the monitoring and evaluation of the worldwide efforts at all operational levels, as described in paragraphs 61-67, 88 and 104 above.

Role of WHO in countries

118. The role of WHO in countries was defined in the Executive Board's organizational study on "WHO's role at the country level, particularly the role of the WHO representatives",[2] which was endorsed by the Thirty-first World Health Assembly (1978) in resolution WHA31.27. For this reason it is being dealt with only in summary fashion in the present document. In conformity with the Board's study and with the concept of technical cooperation as defined by the Health Assembly,[3,4] WHO will collaborate, at the request of the governments concerned, in the formulation of national policies, strategies and plans of action. It will collaborate with the other United Nations agencies and bodies working in the country in support of the national efforts for health and socioeconomic development, such as UNDP and UNICEF.

119. WHO will also collaborate on request in setting in motion the country health programming process and in participating in its implementation, as well as the related introduction of the evaluation process and the strengthening of national health information systems. Similarly, WHO will provide support, on the request of governments, to the follow-up of plans of action, for example in the formulation of specific programmes, the design of health systems based on primary health care, health manpower development, the development and application of appropriate technology, the organization of health services research, and the support of national centres for health development. In keeping with the Health Assembly's decisions concerning technical cooperation,[3,4] and with the process of programme budgeting of WHO's resources in

[1] Resolution WHA31.43.

[2] WHO Official Records, No. 244, 1978, Annex 7.

[3] WHO Official Records, No. 238, 1977, pp. 185-186 and resolution WHA30.30.

[4] See also resolution WHA30.43.

countries, WHO will provide, on request, continuing support to countries' programme priorities that fall within its general programmes of work - which Member States have decided upon collectively - and will facilitate the identification of development activities for external support. WHO will also provide support on request for translating important documents into local languages.

Role of WHO at regional level

WHO regional committees

120. The regional committees of WHO have a crucial role in formulating, implementing, monitoring and evaluating regional strategies and in ensuring political, social, managerial, technical and financial support to national strategies and plans of action. To this end, one of their functions will be to review reports on national strategies and plans of action that have been presented to them in order to permit them to synthesize regional strategies. These will bring together common issues that require the collective action of countries in the region. The regional strategies will in no way usurp the rights of countries in developing their own national strategies. In their efforts the regional committees will be supported by such bodies as regional programme committees and regional advisory committees on medical research and should make full use of other national expertise through appropriate mechanisms such as panels of experts, task forces, and those that will be recommended by the Executive Board in its organizational study mentioned in paragraph 86 above.

121. Regional committees provide frameworks for reaching collective decisions by the countries of the region on regional policies and strategies, and for defining objectives and related targets. Thus, they constitute important regional political fora to promote the idea that an acceptable level of health for all is feasible, and to help overcome obstacles. They should be active in stimulating relevant regional bodies to adopt related social and economic policies. Regional committees should provide political, social, managerial and technical support to national strategies and plans of action, as well as financial support through the assessment of requirements and the attraction of external funds, ensuring that these are channelled into priority activities.

122. Regional committees should create or strengthen regional mechanisms and arrangements to support national action. Thus, they should be instrumental in facilitating agreements among countries on TCDC, including the regional use of national health development centres. They should ensure the regional use of national expertise in other ways, such as through problem-oriented panels, the health development groups mentioned in paragraph 85, and the regional advisory committees on medical research. The latter will be active in ensuring the contribution of biomedical and health services research to the overall regional efforts. The regional committees should be responsible for ensuring the generation and dissemination of relevant and valid information for the countries of the region through an adequate information service, including information required for TCDC. They should identify global implications of regional strategies and should monitor and evaluate these strategies.

WHO regional offices

123. The WHO regional offices will support the regional committees in all of the above, and will act as the instrument for giving effect to the decisions of these committees, and for carrying out those aspects of the regional strategies that are assigned to them by the regional committees. The regional offices will thus, for example, provide the regional committees with information required to formulate, implement, monitor and evaluate the regional strategies. The regional offices will be instrumental in ensuring exchange of relevant information among countries in the regions, including information on practical ways of developing primary health care and ensuring the progressive integration into it of a variety of health programmes. They will support countries in applying TCDC and for this purpose will host the regional bureaux for TCDC, and will help to establish and provide support to regional networks of national centres for health development.

124. The regional offices will promote and carry out direct technical cooperation between WHO and Member States at the request of the governments concerned. They will service the various

bodies and mechanisms involved in developing the regional strategies, such as the regional programme committees, the health development groups mentioned in paragraph 85, and the regional advisory committees on medical research. The regional offices will constitute practical links with relevant regional socioeconomic bodies such as the United Nations regional economic commissions. The regional offices will also deal on behalf of the regional committees with the practical issues involved in attracting external resources and channelling them into priority activities that form part of the national and regional strategies.

Global level

World Health Assembly

125. The World Health Assembly, in fulfilment of its constititional functions, has supreme responsibility for formulating, adopting, implementing, monitoring and evaluating the global strategy for supporting regional strategies and for ensuring political, social, managerial, technical and financial support to national strategies and plans of action. It is suggested that the annual report of the Director-General for 1980, to be presented to the Thirty-fourth World Health Assembly in 1981, should be devoted to progress in formulating national, regional and global strategies. It is also suggested that governments should devote their reports in the plenary session of this Health Assembly to comments on the Director-General's report.

126. The Health Assembly constitutes an important global political forum to promote the idea that an acceptable level of health for all is feasible. It will help to overcome worldwide obstacles. It should be active in stimulating relevant global bodies to adopt related social and economic policies. The Health Assembly will provide political, social, managerial and technical support to regional and national strategies and plans of action, as well as financial support through the assessment of worldwide requirements and the attraction of external funds, ensuring that these are channelled into priority activities.

127. The Health Assembly should ensure the generation and dissemination of relevant and valid information for all countries. It should create or strengthen global mechanisms and arrangements to support regional and national action. Thus it should adopt any necessary policies to facilitate TCDC, and should establish or strengthen global mechanisms and support regional and interregional mechanisms for this purpose. The Health Assembly should ensure the global use of national expertise through such mechanisms as national health development centres, problem-oriented panels, and the global Advisory Committee on Medical Research. The Health Assembly should be responsible for ensuring adequate information support for regional and national strategies and plans of action, including information required for interregional TCDC. It should monitor and evaluate the total global strategy.

WHO Executive Board

128. The WHO Executive Board has an important function in stimulating countries individually, as well as collectively in the regional committees, to launch and sustain strategies and plans of action. In addition, its members should be active in promoting the development of strategies in their own countries. Also, whenever they represent their countries at regional committees and the Health Assembly they should be similarly active in serving these ends. The Board will take steps to ensure that the regional committees assume the functions outlined in paragraphs 120-122 above. It will submit proposals for the global strategy to the World Health Assembly and will support the Assembly in developing, implementing, monitoring and evaluating that strategy. Such a strategy would form one of the bases for the Seventh General Programme of Work covering a specific period, for whose formulation the Board is responsible, as well as for WHO's contribution to the preparation of the new International Development Strategy of the United Nations.

WHO headquarters

129. WHO headquarters will support the Health Assembly and the Executive Board in all the above and will act as the instrument for giving effect to their decisions and for carrying out those aspects of the global strategy that are assigned to it by these bodies. It will thus, for example, provide the Board and the Health Assembly with the information required for them

to arrive at rational decisions. It will ensure that the mechanisms required at the global level function properly, for example, those for ensuring the availability of relevant and valid information, including that required for interregional TCDC.

130. WHO headquarters will ensure the preparation of guidelines required in all regions, such as for the establishment and functioning of national centres for health development, managerial processes for health programme development, the selection and use of indicators for monitoring and evaluation, the integration of a variety of programmes into primary health care, the organization of primary health care by communities, and national health information systems. Headquarters will service the various global bodies and mechanisms involved in developing the global strategy, such as the Programme Committee of the Executive Board, the health development group mentioned in paragraph 102, and the global Advisory Committee for Medical Research. Headquarters will constitute a practical link with the relevant global social and economic bodies such as the United Nations Economic and Social Council, UNDP, UNFPA, UNICEF, and the World Bank. Headquarters will facilitate the process of attracting bilateral and multilateral funds and channelling them into priority activities relevant to the attainment of health for all. One of the ways in which it will do so will be by servicing the global body of participating countries mentioned in paragraph 95 above.

Director-General of WHO

131. The Director-General of WHO, in accordance with his constitutional role as chief technical and administrative officer of the Organization, subject to the authority of the Executive Board, will ensure that the Secretariat at all operational levels provides the necessary support to countries, regional committees, the Executive Board and the Health Assembly for the formulation and implementation of national, regional and global strategies. The Director-General will also ensure that the Secretariat acts as an efficient instrument for giving effect to the resolutions and decisions of the regional committees, Board, and Health Assembly concerning strategies for health for all by the year 2000, and for carrying out those aspects of the national, regional and global strategies that are assigned to the Secretariat by these bodies.

WHO's structures in the light of its functions

132. The possible restructuring of WHO in relation to its role in attaining an acceptable level of health for all by the year 2000 is currently being examined on the basis of a background paper prepared by the Director-General entitled "Study of WHO's structures in the light of its functions" (document DGO/78.1). This study includes the structures in countries for dealing with the political and technical interface between the national authorities and WHO; the regional committees; the regional offices; headquarters; the Executive Board; and the World Health Assembly. Any restructuring of the Secretariat will follow from the restructuring of WHO as a whole. All the above will have to gear themselves to their new role of supporting Member States in developing and implementing the policies, strategies and plans of action.

133. All the regional committees launched the study in their respective regions at their 1978 sessions. Member States are being consulted, either by questionnaires or by visits of regional committee representatives. The regional committees will review the response of governments at their 1979 sessions, following which the Director-General will prepare his report and present it to the Executive Board in January 1980.

VII. TIMETABLE FOR FORMULATING STRATEGIES

134. The timetable on the facing page is suggested.

TIMETABLE FOR FORMULATING STRATEGIES[1]

Date	Member States	WHO governing bodies	WHO Secretariat
May 1979		Thirty-second World Health Assembly: resolution WHA32.30	
late May 1979			Global Programme Committee: common strategy for follow-up action, including review and reorientation of technical cooperation functions and activities
June 1979	Initiate action to obtain commitment at highest governmental and political level		
June 1979			Create special mechanisms as may be desirable and issue guidance covering country progress reporting
July 1979			Meeting of Programme Development Working Group to agree on operational plan for WHO support
from July 1979			WHO high-level contacts by Director-General, Deputy Director-General, Regional Directors and Assistant Directors-General
from July 1979			WHO direct technical cooperation to countries
July-September 1979			Briefing and orientation of WHO programme coordinators, national programme coordinators and key national staff
September 1979			Global Health Development Advisory Council: first meeting[2]
August-October 1979	First reports on initial progress in formulation of national policies, strategies and plans of action	WHO regional committees: review of progress and ways of formulating regional strategies	Regional Directors' reports to regional committees on approaches to strategy formulation, and WHO support, including reorientation of agreed technical cooperation
from September 1979			Meetings and consultations with regional and subregional organizations; groups, meetings, seminars, workshops and similar activities
November 1979		Executive Board Programme Committee: progress review and report to Executive Board, sixty-fifth session	
January 1980		Executive Board, sixty-fifth session: progress review and report to Thirty-third World Health Assembly	
February 1980			Director-General's report to the United Nations Preparatory Committee for inclusion in the New International Development Strategy
May 1980		Thirty-third World Health Assembly: progress review	
June 1980	Submission of reports on national strategies		
June-August 1980			Preparation of information relevant to formulation of regional strategies
August-October 1980	Report on progress and collective formulation of regional strategies	WHO regional committees: progress review and formulation of regional strategies	
October 1980			Preparation of information relevant to formulation of global strategies
November 1980			Meeting of the International Health Funding Group[2]
November 1980		Executive Board Programme Committee: formulation of proposed global strategy and report to Executive Board, sixty-seventh session	
January 1981		Executive Board, sixty-seventh session: review of proposed global strategy and report to Thirty-fourth World Health Assembly	
May 1981	Report on progress and collective review of the global strategy	Thirty-fourth World Health Assembly: review and adoption of the global strategy	Director-General's report to Health Assembly on progress towards national, regional and global strategies
Continuing from May 1981 onwards	Continued development of national plans of action, and implementation of national, regional and global strategies	Periodic progress reviews and evaluation by Programme Committee, Executive Board and Health Assembly	Continued technical cooperation and support to national, regional and global action

[1] The timetable reproduced here, which was reviewed by the Executive Board at its sixty-fourth session in May 1979 (document EB64/2), replaces the less detailed one originally appearing in paragraph 134.

[2] Advisory group to Director-General consisting of national experts.

135. It is realized that many countries may have gone far beyond what is being suggested for inclusion in their strategies and plans of action, or at least that they may have made such progress with respect to certain if not all the issues involved. Other countries may well have a long way to go. It is stressed that the reports from countries to regional committees mentioned in the above timetable should include those issues that form part of the national strategies and plans of action. They need not necessarily include those issues to which the plans of action will lead, such as details of the formulation of priority programmes and of the design of improved health systems based on primary health care.

ANNEX 3

MATERNAL AND CHILD HEALTH[1]

[A32/9 - 3 April 1979]

Report by the Director-General

CONTENTS

[1] See resolution WHA32.42.

I. INTRODUCTION

1. Article 2(1) of the Constitution of WHO states that one of the Organization's functions shall be "to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment".

2. In resolution WHA31.55, the Thirty-first World Health Assembly (May 1978) urged Member States to give high priority to improving the health of mothers and children, particularly as part of primary health care. That recommendation was reinforced by the Declaration of Alma-Ata, which states that primary health care is the key to attaining Member States' social target of health for all by the year 2000, and emphasizes that maternal and child health (MCH) care, including family planning, is an essential part of primary health care.[1] In the same resolution, the Director-General was asked to present to the Thirty-second World Health Assembly, on the occasion of the International Year of the Child (1979), information on the present status of maternal and child health in the world, as well as on trends in the development of relevant services. The report which follows presents that information.

3. The aim of the International Year of the Child[2] is to stimulate sustained international and national action to benefit children and to encourage an investment in childhood now, so that the future will truly be worth living in. By the end of the Year of the Child, there will remain only another 20 years before the year 2000. More than one-third of the world's population in that year has yet to be born (see Fig. 1), and 2500 million of the projected population of more than 6000 million will be under 21 years of age. This has obvious significance for the health care of mothers and children. The span of the remaining two decades represents our greatest challenge - to translate the hope of a New International Economic Order into the reality of health for all. WHO's part in meeting this challenge is reflected in the theme of this year's World Health Day: "A healthy child, a sure future".

4. Infant and maternal death rates may epitomize, more than any other indicator, the gap between the rich and the poor. In many countries, infant and maternal mortality rates have declined dramatically and the health conditions of mothers and children have made impressive progress. Thus the tragic waste of human life can be prevented if proper action is taken. Why then does the health situation of hundreds of millions of mothers and children continue to be so poor? Why, in many countries, does maternal and child health care not receive the priority it should? Many of the answers to these questions apply to the health and development situation in general, for example:

- the low priority given to health as part of development, and the lack of recognition of the contribution health can make to development;
- the enormous constraints facing countries in terms of resources and the environment;
- the tremendous hardships resulting from natural and man-made disasters;
- the inability of the often weak and inefficient health system to give proper support to action at community level.

Other reasons include a lack of appreciation of the basic principles of MCH, its importance for health in general, and its role in overall development and an improved quality of life.

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[1] Alma-Ata 1978: Primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Geneva, World Health Organization, 1978.

[2] See United Nations General Assembly resolution 31/169 of 21 December 1976 in United Nations General Assembly: Official Records, thirty-first session: supplement No. 39 (A/31/39), p. 74.

II. PRINCIPLES OF MATERNAL AND CHILD HEALTH[1]

5. Knowledge gained in the past few decades has clarified the biological and social bases underlying the health and health care of mothers and children. This knowledge has strengthened the scientific justification for the following basic concepts of maternal and child health (MCH) care.

6. There are specific biological and psychosocial needs inherent in the process of human growth which must be met in order to ensure the survival and healthy development of the child and future adult.

7. MCH care is not a form of service, organized conveniently according to the age and sex characteristics of a population group or a specific activity to deal with a given disease. Rather it is concerned with the process of growth and development which is the foundation of human life. It is the nature of this process of growth and development which is crucial for health or ill-health, for life or death.

8. Each stage of growth and development builds on the one before, and influences the next. If the physiological and psychosocial requirements are not fulfilled at each stage, it becomes more and more difficult to catch up or repair the damage done, and thus the body's potential to adapt in a healthy way throughout the process diminishes. The health of the child determines the health of the adult; the growth and development of one generation affects the next generation. Certain stages in this continuous process are more critical or rapid than others, with greater risks. Mothers and children are considered vulnerable groups because of the special characteristics of pregnancy or young age related to the biological processes of reproduction, growth and development. The word "vulnerability" refers to the potential for mis-development - or danger. The process of growth and development is in itself a healthy one, provided crucial elements in the environment are in balance.

9. It is the rapidity of growth and development which causes specific vulnerability, particularly during the third trimester of gestation, the first year of extrauterine life, and puberty. For women of reproductive age - from 15 to 45 years - the vulnerability is related to additional requirements and changes in pregnancy and delivery. Changes, adverse factors and stresses of the ecological system affect pregnant women, the fetus, and the infant even more strikingly than other groups because these stages are critical.

10. The concept of vulnerability has implications for any type of health care. It calls for preventive care, continuity of care for all, individual monitoring, and specific actions when deviations from normal progress are detected. At any point in time from a fifth to a third of the population in most countries could be considered vulnerable. This fact is important for social and health planning in view of the large numbers of people involved, both healthy and not healthy.

11. Understanding the biological reasons for the vulnerability of mothers and children is not an academic exercise; it is essential in order to meet the fundamental health needs of a whole lifetime.

12. If preventive action is taken in pregnancy and early childhood, the effectiveness and impact on health are great.

13. The resources of health systems have usually been allocated to activities for the non-healthy; because of the enormous and urgent demand from this part of the population, very little has remained for health. This has been particularly obvious with MCH care, because it is essentially concerned with the promotion of healthy growth and development and prevention of ill-health.

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[1] The term "maternal and child health", without qualification, is used in the broad and currently accepted meaning of promotive, preventive, curative, and rehabilitative health care for mothers and children, and thus includes the subareas of maternal health, family planning, child health, school health, care for handicapped children, adolescents, and the health aspects of care of children in special settings such as day care.

14. Preventing illness and promoting health entail very basic and concrete measures which form part of a forward-looking orientation to life. Yet it is only in the last few decades that the necessary conceptual, scientific and practical foundations have allowed families throughout the world to plan for their own future or for their children with any degree of certainty. The concepts involved in taking action now for a better life tomorrow have only recently been clearly defined.

15. New knowledge has also shown that many adult health conditions result from problems in childhood. This growing understanding demands a shift of priorities. National health authorities are increasingly realizing that child care is not just the cure of disease in sick children, but the prevention of potentially fatal diseases and incapacity in future adults on whom national health and prosperity will depend, and that greater investment in health care of children means reducing the need for resources devoted to curative health services, hospitals, and rehabilitative facilities, now and in the future.

16. The investment in childhood and child health is a direct entry point into social development and productivity.

17. The concentration of development strategies in the 1950s and 1960s on economic growth assumed the existence of a healthy work force. The emphasis on social development in the 1970s, including social justice, high levels of education and production, organization of communities, and the participation of people in political and social processes, demands not only a physically healthy labour force but also a population with maximum human energy. One factor in past failures to recognize the importance of the contribution of health to development was the failure to recognize the parallel importance of investment in child health. The result today is that the development plans of many countries - responsibly and sincerely written in the 1940s and 1950s - have brought only disappointed expectations.

18. In contrast, there are a number of examples of countries which in the past few decades have made a concerted effort in child health as part of an overall priority investment in childhood. Already one (or in some countries two) generations have grown up since. There is no doubt that this investment has been beneficial for these children (now adults), for their children in turn, and for the prosperity and developmental goals of the nation as a whole.

III. FACTORS AFFECTING THE HEALTH OF MOTHERS AND CHILDREN

19. The environment - natural or man-made, physical or chemical, biological or social - has significant effects on the health status of mothers and children and human development in general. The many factors involved underline the importance of intersectoral approaches to health care in general and MCH care in particular. It is clear that health services alone cannot bring health to the people.

Economics and the environment

20. The differentials in health between rich and poor, which can be observed in all age-groups, are particularly striking among mothers and children. Table 1 illustrates the relationship between crude fertility, infant mortality and economic development, and shows how great these differentials are. But it does not show the pockets of high infant mortality in wealthy countries or the uneven distribution within developing countries.

Table 1

INFANT MORTALITY, BIRTH RATES AND
ECONOMIC DEVELOPMENT

/Source: World atlas of the child, Washington, DC, World Bank, 1979/

Countries	Average GNP (US$ per capita)	Population (million)	Crude birth rate (per 1000 population)	Infant mortality (per 1000 live births)
Industrialized	5 950	1 350	16.2	15
Developing:				
High income	4 127	20	31.0	25
Upper middle income	1 498	108	23.8	35
Intermediate middle income	721	370	41.4	48
Lower middle income	384	215	45.0	88
Low income	151	554	46.6	129
Centrally planned economies	2 112	1 480	17.8	25*

* Excluding China.

21. Among the factors affecting maternal and child health are: agricultural policy and land ownership, which have a direct influence on nutritional status; an unsanitary environment, including unsafe and insufficient water and overcrowding; and transport and communication difficulties. Moreover, urbanization, with its concomitant breakdowns of traditional structures, causes new health problems, such as exposure to pollution, social and mental deprivation of children, increased risks of sexual exploitation and drug abuse among the young, and so on. Cities are built for adults, and urban planners rarely recognize the importance of the physical surroundings for health and for accommodating children amid the concrete maze.

Social values and education

22. A society's traditions, cultures, philosophies and religion all shape people's understanding and conception of health, sickness and death. Various harmful effects have been seen as a result of, for instance, food taboos in the treatment of sickness in children and the eating practices of pregnant women, child marriage, and discrimination against female babies. On the other hand, there are positive aspects, such as the traditional bonding or close contact of mother and infant, and the value attached to cleanliness and personal hygiene in many religions. While changes in traditional family life-styles are inevitable, every community must make an effort to see that valuable practices such as breast-feeding are not allowed to disappear. There is sound sense in creating the new by grafting on to what was best in the past.

23. The relationship between educational factors (formal and nonformal schooling, literacy, and traditional forms of education) and health are complex and not easily described. However, associations have often been found between high levels of infant mortality and low levels of education.

The family

24. There is a growing consensus that the family, with its structures (the pattern of family formation, size, age of parents, etc.) and functions, not only influences the health and disease pattern of the individual and the community but is also a logical unit for self-reliance in health care and a channel for improved delivery of health and other social services.

25. Life-styles, including physical activity, personal hygiene, drinking and eating habits, and attitudes to health, are shaped in early childhood through the dynamic interaction of all members of the family. Behaviour and attitudes within the family, and of all its members, are vitally important for the development of the child in its early years; they largely determine the response pattern of the child in its progressive socialization within the family and outside.

26. It is often rightly said that the mother is the family's first health care worker. To be able to fulfil this role, she needs to be given support by several types of social services, since women often lack access to information and technology, to income and education, and they must cope with an overload of work, usually without support.[1] In more and more areas of the world today, man-made and natural disasters, including war and other violence, political upheavals, changing patterns of women's work, and migration of men away from rural areas are having far-reaching effects on the family's functioning, especially with regard to child-bearing and child-rearing. The supporting mechanisms which the family has provided in the past may be eroding because of economic and social pressures far beyond its control. All these factors profoundly affect the health of mothers and children.

Social support, including health care

27. The many factors affecting the health situation of mothers and children also include community and social support measures, ranging from neighbourhood-oriented day care facilities to organized health care systems (see section VI).

IV. THE HEALTH STATUS OF MOTHERS AND CHILDREN

28. As suggested in section III, health cannot be achieved where poverty and misery are rife, where food and safe water are scarce, where housing is inadequate, and where public and community services are lacking or rudimentary. In such conditions, faced by such large numbers of the world's people, ill-health and premature death are the rule of the day. The most important causes of mortality and morbidity of infants and young children are multiple and nonspecific, associated with the interaction of malnutrition, infection and the consequences of unregulated fertility.

29. Of the world's total population, estimated at 4219 million in 1978, women of reproductive age represent 24% and children below 15 years of age 36%. While the proportion of women of reproductive age in the population is about the same in all parts of the world, the proportion of children under 15 years of age is 24% in the developed areas and 40% in the developing areas. Thus, while the actual percentages may vary from one country to another, these two groups together make up the majority of the population in almost all parts of the world today:

[1] Report of the Meeting on Women and Family Health, 27-30 November 1978. Geneva, World Health Organization, 1979 (unpublished document FHE/79.1).

World population estimates (1978)

/Sources: Population Reference Bureau and United Nations
(Selected world demographic indicators)/

	World	Developing areas	Developed areas
	(millions)	(millions)	(millions)
Total population	4 219	3 105	1 114
Women aged 15-49 years	1 005	727	278
Children aged 0-4 years	565	472	93
Children aged 5-14 years	957	778	179

30. The lack of reliable data is a severe obstacle to a global analysis of health status. In the first place, it is increasingly being questioned whether the well-known collections of data on mortality and morbidity do, in fact, appropriately reflect health status. New, and positive, indicators of health are emerging, such as indices of growth and development as well as maturation during adolescence. Birth weight is an important example; it reflects both the past and present health status of the mother, and is sensitive in predicting the chances of an infant's survival and subsequent health.

31. The inadequacies of data on mortality and morbidity, particularly in those parts of the world where the health problems are most severe, are most acute for pregnant women and children, especially the newborn. These limitations should be kept in mind when interpreting the data reviewed in this report.

Maternal mortality and morbidity

32. In countries with a well-developed health service and in which the maternal mortality rate is well documented, the rate has decreased steadily and is of the magnitude of 0.5-3 per 10 000 births. From most developing countries, the few available data refer only to hospitals; however, where the incidence can be calculated with some confidence, the rates are much higher than in the developed world. For example, in Peninsular Malaysia in 1966 the rate was 17 per 10 000 births, but ranged from 3.1 to 55.8 for individual districts. In a large survey in rural Bangladesh, the overall maternal mortality rate was 57, with a rate among the youngest mothers as high as 177 per 10 000 births. At such levels, maternal mortality becomes a leading cause of death among women. In areas with the highest rates i.e. most of Africa and West, South and East Asia, about half a million women die from maternal causes every year, leaving behind at least one million motherless children. In Latin America, the maternal mortality rates are much lower, but several studies have shown serious under-reporting of maternal causes of death; in some countries up to half of such deaths were not reported accurately.

33. Among the causes of maternal deaths, toxaemia is one of the most important, not only in the developed countries where it accounts for 25-35% of all maternal deaths, but probably even more so in the developing countries. It appears to be associated with very young mothers and with maternal depletion and malnutrition in high parity women. The effect of close pregnancy spacing is also manifested in higher neonatal and infant mortality rates (see Fig. 2). Post-partum haemorrhage, often with anaemia as an underlying or associated cause, and sepsis are frequent causes of maternal death. Anaemia and toxaemia, in addition to their effect on maternal mortality, also cause high rates of fetal deaths and low birth weight.

34. The role of illegally induced abortions as an underlying cause of maternal death is well recognized, but difficult to estimate, even approximately, because of the secrecy surrounding abortion as a cause of death.[1] In Latin America, where abortion is illegal in

[1] See WHO Technical Report Series, No. 623, 1978 (Induced abortion: report of a WHO Scientific Group).

most countries, it has been estimated that abortion is the cause of between one-fifth and one-half of all maternal deaths.

35. Reliable data are even more scarce for maternal morbidity. Anaemia is widespread among women of child-bearing age, in developed and in developing countries. In the latter the percentage of non-pregnant women with haemoglobin levels indicative of anaemia ranges from 10% to 100%, and in developed countries from 4% to 12%. Chronic malnutrition and anaemia, closely interrelated with acute and chronic infections such as malaria, infectious hepatitis, urinary tract infections and pulmonary tuberculosis, cause much suffering. Malaria in particular is of widespread importance: in endemic areas pregnant women lose their immunity; malaria attacks are more severe during pregnancy; and malaria of the placenta increases the risks of low birth weight.

36. These mainly preventable diseases contribute greatly to maternal mortality, while anaemia of pregnancy has been found to be a contributory cause of up to 80% of maternal deaths in parts of Asia. Almost all chronic diseases, such as hypertension, renal diseases and diabetes are aggravated by ill-spaced pregnancies and high parity. Addictive drugs, alcohol consumption and smoking during pregnancy can lead to intrauterine growth retardation and even malformation. Psychological stress factors are also of increasing concern.

37. No review of maternal health problems would be complete without mention of involuntary infertility, a condition which can cause great personal distress and have important social implications. In most parts of the world, the condition is relatively infrequent, affecting perhaps 2-10% of couples, but in certain areas of Africa childlessness may be as high as 40%. It is suspected that the causes of this high prevalence include sexually transmitted disease resulting in tubal obstruction, as well as chronic obstetric sequelae.

38. What is not brought out by these figures is the enormous suffering that women have to cope with in many parts of the world. They are expected to continue caring for their family, and to carry heavy work-loads in the field, or in the office for that matter, in spite of physical stigmata after abortions or frequent pregnancies, and in spite of intense fatigue due to anaemia or lack of sleep. Child abandonment, child abuse and - even more so - infanticide are desperate acts in reaction to unbearable economic, social and health conditions.

Infant and childhood mortality.

39. Of the some 122 million infants born in 1979, roughly 10% will die before reaching their first birthday, and another 4% before their fifth birthday. But the chances of survival are very unevenly distributed in the world, as indicated in Fig. 3 for six major regions. Thus, while the risk of dying before reaching adolescence is about 1 in 40 in developed countries, it is 1 in 4 in Africa as a whole and even 1 in 2 in some countries. Table 2 shows the child populations and child deaths in more detail by 20 regions, ranked in order of increasing life expectancy at birth. Inevitably, the averages in this grouping conceal many local variations and disparities. On the other hand, the presentation does highlight the vast differences between the regions, in particular between those areas where the life expectancy is below 60 years (Africa and South Asia) and the rest of the world. In some of the former areas, nearly two-thirds of all deaths are those of children below 5 years (Fig. 4).

40. A review of trends in many parts of the world indicates that infant and childhood mortality rates are declining. In developed countries the infant mortality rate (IMR) has fallen by 2-7% a year since 1960, the decline being most marked in countries with the highest initial rates. The most spectacular reduction has taken place in Japan, where the IMR fell from 60 in 1950 to 31 in 1960 and 11 in 1974. A goal of 40% reduction of IMRs was set in the Ten-Year Health Plan for the Americas (1971-1980). By 1975, of 32 countries of the Region for which data were available, 15 had reduced their rates by 20% or more as compared to 1970. Encouraging as these trends are, they cannot be assumed to extend to all parts of the world, and might even accentuate the global disparities.

Table 2

VITAL STATISTICS BY GEOGRAPHICAL REGIONS, 1978
(in millions unless otherwise stated)

Region	Life expectancy at birth (years)	Population			Annual number of births	Annual number of deaths of children aged		Deaths of children under 5 years as percentage of all deaths
		total	children aged			under 1 year (thousands)	1-4 years (thousands)	
			0-4 years	5-14 years				
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
West Africa	42	128	24	34	6.3	1 010	564	55
Middle Africa	42	50	9	13	2.2	381	215	61
East Africa	45	124	23	33	5.8	845	629	60
Mid South Asia	49	879	145	232	32.5	4 423	1 609	46
Southern Africa	52	31	5	7	1.2	150	65	44
South-East Asia	52	341	58	91	12.6	1 463	352	41
Northern Africa	52	103	18	28	4.4	580	399	68
South-West Asia	55	92	16	24	3.9	423	128	48
Tropical South America	61	188	31	50	7.0	689	163	50
Middle America	63	87	16	24	3.6	256	79	48
Caribbean	64	28	4	7	0.8	53	8	27
East Asia	66	1 122	131	236	24.7	1 431	631	23
Temperate South America	66	40	4	8	0.9	66	9	21
Oceania	68	22	3	4	0.5	13	2	8
USSR	69	261	22	45	4.7	132	12	6
Eastern Europe	70	108	9	16	1.9	49	8	5
Southern Europe	71	137	11	24	2.3	56	9	5
Western Europe	72	153	11	25	1.8	28	6	4
Northern Europe	72	82	6	13	1.1	14	3	2
North America	73	242	19	43	3.6	54	10	3
World	60	4 219	565	957	121.8	12 115	4 901	25

Sources: Cols (1), (2), (5) - Population Reference Bureau, 1978 estimates.
Cols (3), (4) - Population Reference Bureau and United Nations (Selected world demographic indicators, 1975).
Cols (6), (7) - WHO (Division of Family Health) estimates from various sources.
Col. (8) - Cols (6) and (7) and Population Reference Bureau.

Notes: Totals were calculated before rounding; rounded figures may not add up to totals.
Col. (8) - Figure for northern Africa is greatly influenced by the estimated fall in the overall death rate (United Nations estimate).

41. Regardless of the level of child mortality, the probability of dying is at its peak at the time of birth, including the period immediately before birth; it declines thereafter. Both the probability of dying and the main causes of death change rapidly during the early years of life. The conventional distinction between perinatal (28th week of gestation to 7th day of life), neonatal (first 28 days of life), post-neonatal (28th day to one year), and child (1-4 years) mortality is thus convenient from both the analytical and the programmatic point of view. Of particular importance is the different impact on mortality in each of these periods of adverse environmental factors, especially nutrition. In countries where infant and child mortality have been reduced, mortality in ages 1-4 years has fallen first and most rapidly, while perinatal mortality has declined much more slowly. The enormous difference in mortality rates from country to country is illustrated below:

National maternal and child mortality rates: comparison of extreme levels

/WHO (Division of Family Health) estimates based on data from various sources/

	Highest rate (1)	Lowest rate (2)	Ratio (1)/(2)
Perinatal mortality[1]	120	12-15	8-10
Infant mortality[1]	200	8-10	20-25
Child mortality[2]	45	0.6-1	45-75
Maternal mortality[3]	100	0.5-1	100-200

[1] Per 1000 live births.

[2] Per 1000 population.

[3] Per 10 000 live births.

42. Perinatal mortality now accounts for about 90% of all fetal and infant mortality in the developed countries with the lowest IMRs. The underlying causes of perinatal deaths are closely linked to those of maternal deaths, i.e., poor health and nutritional status of the mother and complications of pregnancy and childbirth.

43. Perinatal mortality is also closely associated with low birth weight, defined as a birth weight below 2500 g: this risk factor affects mortality in the whole first year of life and probably also in the following few years, as well as having adverse long-term effects on the development of the child. A WHO study in seven developed countries revealed incidences of low birth weight of between 4% and 11%, yet deaths of low-birth weight babies accounted for between 43% and 74% of all perinatal deaths. An estimated 22 million such babies are born each year, 21 million of them in the developing countries, mostly among the least privileged populations (see Fig. 5). There are strong indications that these babies contribute to a large proportion of infant deaths and child morbidity, the mortality risk being 20 times higher than that for other babies both in the neonatal period and later.

44. Infant deaths taking place after the first week (i.e., late neonatal and post-neonatal deaths) have become quite rare in developed areas. However, in developing countries the infant deaths after one week still account for about two-thirds of all the infant mortality. With a few exceptions such as tetanus, which in some areas kills up to 10% of the newborn, the causes of these deaths are multiple and ofter ill-defined. Diarrhoeal disease is the leading cause of infant morbidity and mortality mentioned in most studies, followed closely by respiratory infections (see Fig. 6). In one large study, malnutrition was mentioned as the underlying or associated cause of 57% of infant deaths.[1]

[1] Puffer, R. R. & Serrano, C. V. Patterns of mortality in childhood: report of the Inter-American Investigation of Mortality in Childhood, Washington, DC, Pan American Health Organization, 1973 (Scientific Publication No. 262).

45. The numerous advantages of breast milk and breast-feeding are now well recognized. Throughout the first 4-6 months breast milk satisfies all the nutritional requirements of the young infant. During this time it also provides the anti-infective properties that help protect the young infant from many common diseases. For example, diarrhoeal diseases are less common and less severe in the breast-fed infant. After the first 4 to 6 months, when additional foods should be added to the diet of the infant, breast milk continues to constitute a valuable nutritional source. Increased morbidity and mortality in infancy is, in many parts of the world, associated with changing infant feeding patterns, especially the decline in breast-feeding. The WHO Collaborative Study on Breast Feeding[1] shows that in urban areas in many developing countries the prevalence of breast-feeding has declined, sometimes to levels lower than are current in some industrialized countries. The duration of breast feeding, moreover, is also in many cases shorter than desirable. Only in the rural areas of most of the developing countries studied is long duration of breast-feeding the practice. In some of these, however, there is the additional problem of delayed introduction of supplementary foods.

46. Mortality in the age-group 1-4 years is much lower in all populations than infant mortality. The infectious diseases of childhood, such as measles, whooping-cough and pneumonia, begin to appear at the end of the first year or in the second year of life. Combined with malnutrition, these diseases can lead to high case fatality rates. For example, during the famine in the Sahel the case fatality rate for measles was estimated to be up to 50% in some areas, whereas in other parts of tropical Africa the rate is 7-10%.

Childhood morbidity

47. For every fatal outcome, there are many episodes of disease and ill-health. In addition, many common childhood diseases and conditions do not usually kill their victims, but may cause serious, chronic damage. Some of this is already apparent in childhood (blindness, paralysis), while other damage will become manifest only later in life (chronic heart disease, mental retardation).

48. In the developed world accidents, which are the leading cause of death of children aged 1-4 years, also result in a substantial amount of disability. In the United States, for example, about 300 000 children are hospitalized annually because of head injury and some 20 000 of these will suffer some degree of permanent brain damage. There is every reason to believe that accidents among children are frequent also in the developing countries, especially burns and traumas from home accidents, but their relative importance is much less.

49. Another child health problem increasingly recognized as important in most countries is behavioural disturbance.[2] In some countries young children abandoned by their families present severe social and health problems; for example there are estimated to be 2 million such children in Brazil and 1.5 million in India.

50. Without question, malnutrition is numerically the most important condition affecting the health of children of the world, particularly in the developing countries. Some 100 million children under 5 years of age are suffering from protein-energy malnutrition - more than 10 million of them from severe protein-energy malnutrition, which is usually fatal if untreated. Generally speaking, the prevalence is highest in Africa, where in some areas up to 23% of children aged under 5 years are suffering from severe, and up to 65% from moderate, protein-energy malnutrition.

51. Other nutritional deficiencies include an insufficiency of vitamins A and D. The extent of blindness in children, primarily due to vitamin A deficiency, is tragic: an estimated 100 000 children become blind every year. In spite of the abundance of sunshine, which promotes the synthesis of vitamin D in the body, children in parts of Africa and Asia suffer from rickets mainly because of traditional beliefs about child-rearing. This problem may also be found in migrant populations in the industrialized countries.

[1] In preparation.

[2] See WHO Technical Report Series, No. 613, 1977 (Child mental health and psychosocial development: report of a WHO Expert Committee).

52. In every society, mortality and morbidity in the age-group 5-9 years are much lower than in younger children. Still lower mortality is found in the 10-19 year age-group. Accidents account for about half of all deaths;[1] the next most important causes of death are suicide and malignant diseases, including severe blood disorders, in the more developed regions, and gastrointestinal and respiratory infections, including tuberculosis, in other areas. A disturbing trend is the recent increase in suicide rates for adolescents and the abuse of alcohol and other addictive drugs. In many countries suicide is the second leading cause of death in the 15-19 year age-group.

53. In most industrialized countries the incidence of sexually transmitted diseases among adolescents is more than twice as high than it is among those aged 20-29 years. Early teenage pregnancies pose special health risks not only for the mother, but also for the child.[2] Evidence clearly shows that maternal mortality ratios are considerably higher for younger women, and that teenage mothers also run a higher risk of losing their babies in infancy.

V. DEVELOPMENTS IN MCH: TECHNOLOGIES AND KNOWLEDGE

54. In the past few decades, there have been important advances in science and technology which have affected the health of mothers and children. Vast rural and periurban populations have, however, remained untouched by them. Technologies have to be developed which are appropriate to the local needs and life style of communities and which can be used by primary health workers or the families themselves. In the industrialized countries the technological development has been rapid, with a trend towards more sophisticated techniques and the development of potent curative drugs. In obstetrics, the main developments have been availability of life-saving oxygen and transfusion facilities and antibiotics, technology for fetal monitoring, and improved techniques for the induction of labour and for obstetrical analgesia. These were coupled with such negative institutional practices as separating the mother and newborn child and inducing labour on weekdays to avoid weekend births. The technology developed, although beneficial when used rationally, has tended to interfere with a basically healthy, normal process. As with almost every advance in technology, it has called for new and expensive mechanisms and organizations to protect individuals and families against its ill-effects. The effects of over-use (or extremes) of these technologies and types of care have been challenged, both by the public on the grounds of expense and the inhuman nature of the care, and by clinicians on the grounds of their potential danger.

55. Prenatal and postnatal screening for metabolic, congenital or genetic disorders in the fetus and newborn have been made possible by sophisticated biochemical and cytological devices; amniocentesis is an example. Other advances have included treatment for infertility. The care of the newborn has progressed greatly through better knowledge of the physiology of kidney, gastrointestinal and lung function, and heat-regulation. This has made possible relevant techniques of anaesthesia, intravenous nourishment, etc. Treatment of episodes of illness, in such diseases as meningitis and pneumonia, is now very successful. Some malignant diseases of the infant are controllable. Surgical corrections of malformations and traumas are very effective.

56. Child psychology and psychiatry are becoming influential in general paediatric care. The care of children with chronic disorders is more and more looked upon as part of family health. Likewise, rehabilitation measures have been taken from institutions into the family, and a variety of supportive measures have been developed.

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[1] WHO Technical Report Series, No. 609, 1977 (Health needs of adolescents: report of a WHO Expert Committee).

[2] Omran, A. R. & Standley, C. C., ed., Family formation patterns and health. Geneva, World Health Organization, 1976.

Preventive technology

57. Examples of preventive technology in MCH include the development of vaccines for the prevention of a number of the common infectious diseases of childhood, of immunization techniques such as the jet-injector, and of simple cold storage systems. Immunization has greatly reduced the incidence of diphtheria, whooping-cough, tetanus, tuberculosis, measles, and poliomyelitis.

58. The availability of effective modern contraceptive technology has not only contributed to lowering infant and maternal mortality, but has also made possible radical changes in the lives of women in society and in the family. Technological research in this field has largely concentrated on finding new methods or devices which are safe, effective and increasingly simple to use and administer. Also, better technologies have made abortion a safer and simpler procedure.

59. The prevention of diseases and disorders resulting from nutritional deficiencies has been enhanced through the development of techniques for the fortification of foods, e.g., the fortification of sugar with vitamin A and salt with iodine. These techniques have become widespread and have done much to reduce or even eliminate the incidence of the deficiencies.

60. Although not a preventive technology per se, the development of a simple method of oral rehydration therapy for treatment of diarrhoeal diseases in young children has potential for significantly reducing the great number of deaths now caused by these diseases. With appropriate information the method can be easily used by the primary health care worker and by a family member - mother, father or others.

Developments in knowledge

61. Other developments in the past few decades related to scientific knowledge in MCH have had an impact on health and social interventions for mothers and children: e.g., greater understanding of critical periods of growth, the human potential for "catch-up", and the impact of "parenting" on psychosocial development of the child. In recent years it has become quite clear that many of the foundations of later health are to be found in the important first 40 weeks after growth starts, at conception. Increased knowledge of fetal development has led to increased attention to the intrauterine environment. Both epidemiological and intervention studies point to the crucial importance of the last trimester of pregnancy, which is the main energy storage period of fetal life.

62. It was less than 40 years ago that the possibility was widely recognized that environmental factors during fetal development, especially the first trimester, caused malformations in humans. This was underlined by observations of the effect of rubella on the young fetus, and then by the disclosures concerning the thalidomide tragedy, which drew attention to the still under-researched area of perinatal pharmacology.

63. In the 1970s, results of research have made it increasingly clear how events in early life affect the health of the adult, and how many conditions can be prevented through early action. For example, dental disease in adult life can be almost totally prevented by action in childhood. Early treatment of streptococcal infections in childhood can prevent rheumatic heart disease. In spite of the evidence that genetic factors play a role in essential hypertension, longitudinal studies suggest that the foundations of hypertension in susceptible individuals may well be laid in early life.

64. The effects from one generation to the next of adverse environmental conditions - especially undernutrition - are manifested, for example, in delayed menarcheal age in developing countries, as well as in the adverse effects of small stature of the mother on outcome of pregnancy. Studies have shown the synergistic effects of malnutrition and infection, and have demonstrated that malnutrition - especially protein-energy malnutrition - is a contributing or associated factor in more than half of childhood deaths. In industrialized countries overnutrition has become a major problem; because treatment generally fails, prevention becomes of prime importance.

65. Knowledge of the importance of breast-feeding is leading to action to reverse the trend away from this practice in some areas, and to maintain breast-feeding in others. Studies on breast-feeding conclusively show that breast milk not only meets all the nutritional needs of the baby safely and adequately, but it also provides the baby with defences (immunities) that protect against many of the illnesses of early infancy. Studies in recent years have also "proved" the significance of the early mother-infant contact, or "bonding", for infant and child development.

Research needs

66. As to future research needs, findings and prospects, more knowledge should accumulate during the coming years as a result of research in cell biology, immunology and pharmacology. Powerful tools may be discovered to replace missing enzymes in children, the lack of which causes genetic disorders, and to replace defective genes with healthy ones. It may also be possible to combat respiratory diseases, leprosy and malaria by immunization, and to monitor drug metabolism according to individual characteristics and nutritional status.

67. In the past, much less emphasis was laid on developments in social sciences and on operational and health services research in MCH as part of the health care system. A new balance in research has to be struck in all countries, with due attention to the cultural background and an epidemiological analysis of prevalent health problems. The process of socialization of the young child and the adolescent is not yet well understood. This topic calls for multisectoral involvement and has great significance in optimizing the educational system. Many of the roles of women must be better understood and supported to the benefit of society as a whole. Much more needs to be known about the quality and quantity of family self-care in child-bearing and child-rearing, and effective social support systems need to be studied and developed. The efficiency and effectiveness of the health care system should be studied at all levels in various settings. This will include the study of approaches to community participation in decision-making, problem identification and programme implementation.

VI. TRENDS IN MCH CARE WITHIN THE HEALTH CARE SYSTEM

68. MCH care is now planned and implemented as an integral part of the health care system as a whole.[1] Furthermore, in the past decade family planning has increasingly been included as an integral part of MCH. The present emphasis is on the development of MCH care according to the primary health care approach, as one of its essential elements.

69. The content of MCH care cannot be uniform, as problems and solutions will vary from one community to another. Nevertheless, as an essential element of primary health care it might include: care during pregnancy and childbirth; promotion of breast-feeding and appropriate infant and young child nutrition; supervision of growth and development and prevention of infections, including immunization; the prevention and management of infant and childhood diarrhoea, including oral rehydration; family planning, including prevention and treatment of infertility; education in health within the family in support of family self-reliance.

Organization of care

70. The first "level" of MCH care within the health system is the home and the community; it is estimated that nearly 80% of the tasks of the primary health care worker are related to health care of mothers and children. Maternity homes with facilities for hospitalization function at district levels for referral and services such as caesarian sections, neonatal care, and laboratory diagnosis. Depending upon the overall structure of a national health care system, the intermediate levels of MCH care provide support to the requirements at the peripheral levels, and the necessary facilities for referral for problems which cannot be dealt with at

[1] WHO Technical Report Series, No. 600, 1976 (New trends and approaches in the delivery of maternal and child care in health: sixth report of the WHO Expert Committee on Maternal and Child Health).

previous levels. Paediatric and obstetric outpatient facilities or hospital beds exist in all countries, usually at central and district levels. At the central level in the past 30 years nearly all countries have established, within the ministry of health or other related ministries, MCH units to provide guidance in technical policy and planning with regard to training and service.

71. Evaluation of numerous service programmes has shown that many specific measures and interventions have been rigidly repeated everywhere, irrespective of their relevance to the real needs of the local situation, resulting in misuse of already scarce resources. This is particularly true of prenatal care. New planning methods are being developed to permit more effective MCH care, including the "risk approach" being promoted by WHO.[1] This approach fits into the overall process of planning and programming carried out within the national system.

72. Much of the health care of mothers and children in the past has been delivered separately, with different clinics being held at different times, by different staff. Immunization and family planning are examples of services which in some instances have been and still are fragmented, sometimes to the detriment of MCH care in general. Studies of service coverage in these circumstances have shown that personnel and other resources are drawn from other services providing more general MCH care, resulting in reduced effectiveness or acceptance. In recent years, most of the previous vertical family planning programmes in Asia, for example, have changed their policies and are now combining family planning with other elements of MCH care and family welfare. In various industrialized countries, there is now a trend away from the fragmentation of MCH care towards a broader family-oriented form of care.

73. One of the main conclusions of the joint WHO/UNICEF study on alternative approaches to meeting basic health needs in developing countries[2] was that the integration of components of health services yielded the best results. The main common feature of integrated care was the use of field workers, who carried out MCH care functions and who served as a link between the village families and other levels of the health services.

74. As the concepts of integrated, comprehensive health care and the principles of equity in health care have been increasingly accepted, there has been a rethinking and departure from the conventional "MCH services": now every contact of mothers and/or children with the health care system is seen as an opportunity to deal with the health problems of all the members of the family, and to see each individual's problems and needs in the context of the family and community.

Manpower and training

75. The shortage of manpower, the poor utilization and maldistribution of existing manpower, and the inadequate and/or irrelevant training received are among the main obstacles to ensuring total coverage of populations with essential and socially relevant health care. This is particularly acute in relation to MCH, mainly because of the factors described above. The characteristics of MCH have implications in terms of planning for the types of activities and the time spent by health and other community workers in MCH care, especially front-line workers, as well as for the number of workers required.

76. The special "MCH worker" category at the primary level is gradually being phased out. A wide range of workers are now considered to be needed for MCH care: they include persons who are not only workers in the formal health sector, but also those in other sectors, both formal and informal. At the community level this would include primary health care

[1] Risk approach for maternal and child health care. Geneva, World Health Organization, 1978 (Offset Publication No. 39). The approach is a managerial tool for the flexible and rational distribution of existing resources, based on measurements of individual and community risks, and for developing local strategies and determining the appropriate content of MCH and family planning care, to permit improved coverage.

[2] Djukanović, V. & Mach, E. P., ed. Alternative approaches to meeting basic health needs in developing countries. Geneva, World Health Organization, 1975.

workers, crèche staff, extension workers, grandparents, members of women's organizations, schoolteachers, and traditional birth attendants. However, in most instances training in MCH has not as yet reached much beyond health workers.

77. Much of the training in MCH for health workers before the 1970s was based on curricula devised in academic situations, without taking into account the local conditions at the periphery. Moreover, in developing countries the training of health professionals was based on foreign models; many of the paediatricians and obstetricians, professional midwives and MCH managers were trained outside their own countries in university centres in developed countries. The content of training was therefore usually not relevant within the local social context of the workers or people at the community level, nor was it geared to the solution of major health problems of those at the social periphery.

78. Current trends, on the other hand, show that it is more effective to develop the curriculum from the community level; that is, the development of training curricula should start with a full knowledge and appreciation of the community and the tasks of the community level workers, and build up from there to the curriculum of their teachers, and then of professional and supporting personnel at teaching institutions, universities and postgraduate level, including specialist paediatricians and obstetricians/gynaecologists.

Availability and utilization

79. Recent World Health Assemblies, as well as the 1978 International Conference on Primary Health Care, have expressed increasing concern as to the inadequate coverage of health services in most countries and the fact that the health needs of populations are not being met. This is despite the efforts made in many developing countries to strengthen the health services. In most countries the bulk of resources are still used for urban specialist and hospital care. In a large Asian country, for example, only 32% of the rural population lived within a three-kilometre radius of any kind of health facility at the end of 1975, while the corresponding percentage for the urban population was 98%.

80. Services may also be under-utilized; some of the reasons for this are specific to MCH as they relate directly to the lives of women, who are the main "users". The overburden of work in women's lives has been referred to in general terms; in many areas, women may spend the day in agricultural work, fetching water, preparing meals, and marketing. Limitations of time and energy may thus be important obstacles for them. Also, in some societies, women prefer to consult or be examined by female health workers, who may not be available.

81. A meaningful measure of coverage in MCH care should be more than a count of health facilities and health staff per person. It should show how the whole series of promotive, preventive, curative and rehabilitative activities are made available to, and perceived and utilized by, those in need. Thus appropriate coverage data for MCH care are practically non-existent, particularly for underserved population groups. There are, however, service statistics for several components of MCH care which give some indication of coverage. These are outlined below.

82. Care during pregnancy and childbirth. Care during pregnancy and childbirth is provided in different forms, with special clinics, outpatient and other services involved. Although data are difficult to summarize at a global level, it is known that coverage with prenatal care is expanding in individual countries. In Botswana, for example, the proportion of pregnant mothers attending prenatal clinics rose from about 40% in 1973 to about 70% in 1977. There is also a trend towards increased attention to the identification of high-risk pregnancies.

83. Figures for births attended by trained personnel in developing countries show a wide range among regions: in Africa, the figures for countries range from 6% to 67%; in Asia from 3% to 95%; and in Latin America from 12% to 97%. Nevertheless, the proportion of deliveries attended by trained personnel is rising steadily in many countries. However, a review of the most recent information suggests that in some parts of the world at least 50%, and in a few instances as many as 85%, of births are assisted by traditional birth attendants

or relatives. Although in the past traditional birth attendants were not officially recognized by many health authorities, and thus received no support, more and more countries are now devoting attention to their training and utilization, and providing access to supervision and referral for MCH and family health care.

84. Family planning. With the growing recognition of the health and social benefits of family planning, particularly to mothers and children, more countries are integrating family planning within their national health programmes. According to a recent global survey, the percentage of eligible women practising family planning nearly doubled in some regions during the first half of the 1970s, and it was estimated that in 1976 34% of eligible couples throughout the world were using some form of contraception regularly. However, there is great variety within and between countries; for example, an estimated 53% of eligible women practised family planning in the Western Pacific Region, whereas in West Africa the figure was only 3%. A series of fertility surveys in all parts of the world showed a large proportion of women who did not want any more children, yet who did not have the information or means to practise contraception.

85. A comparison of rates of use of contraceptive methods delivered through health care services in 1971 and 1976 indicate that coverage has increased significantly in the five-year period. Among couples practising family planning, the percentages of those using oral contraceptives, intrauterine devices (IUDs), and sterilization increased.

86. About two-thirds of the people of the world, mostly in Asia, Europe and North America, live in countries where there are liberal abortion laws and policies. The remaining one-third live in countries, mainly in Latin America and Africa, but including a few in Europe, where abortion is either illegal or permitted only to protect a woman's life or health. Whatever the legal status, induced abortion is widely practised in most parts of the world and, according to estimates, accounted for about one pregnancy termination for every three live births in the mid-1970s, with approximately half of the induced abortions performed clandestinely.

87. Infertility care has received increasing attention in many countries but in most of the developing world it remains a specialized service reserved for a privileged few.

88. Infant and child care. In developing countries, national data for infant and child services are even more difficult to obtain than other components of MCH care; and the "content" of such services varies. In general, however, it includes continuous supervision of the growth and development of the child; prevention and management of common infections and specific childhood diseases; and promotion of good nutrition. The figures for specific activities such as immunization thus give some indication of "coverage". At the present time, it is estimated that less than 10% of the children born each year are immunized against the six common childhood diseases (pertussis, tetanus, diphtheria, measles, tuberculosis and poliomyelitis). It can be assumed that these 10%, at least, also receive appropriate preventive health care in other respects. But in spite of growing realization of the importance of such care, the large majority of the world's young children come into contact with the health service only when they need curative care.

89. Family life education. While mothering and fathering are known to be powerful influences on the development of the young child, adequate counselling in this matter is rarely provided to mothers during pregnancy, and even less to fathers. Moreover, health education on ways and means of improving the health of mothers and children is commonly treated marginally within the health services. This is mainly due to such factors as pressures of time, inadequate preparation of the health workers, and lack of suitable educational materials.

Other relevant services and legislation

90. The health care of children is not limited to interventions through the health care system; other related social services are closely involved, some of which are indicated below.

91. Day-care services/facilities. The day-care of children is becoming more important as the tendency for both parents to work outside the home, or far away from the home environment, increases. This also reflects a trend towards an increase in the social support required for child-rearing.

92. Devastation caused by war presents the problem of thousands of homeless and orphaned children. After the First World War in some countries - for example, the USSR - collective care of pre-school children began with very successful results, and state involvement in institutionalized day-care developed rapidly. Paediatricians and psychologists have provided guidance since that time. In 1977, 12 million children in the USSR attended day-care institutions such as nurseries, kindergartens, pioneer camps and children's homes. Other countries in Europe have developed day-care facilities along similar lines. Recent figures show that the percentage of children aged 3-5 years attending day-care institutions in Europe ranges from about 27% to 90% in the different countries. The percentages of younger children being provided such care are lower, i.e. about 7-25%.

93. In developing countries, there are very few examples of governmental efforts to implement day-care systems. Isolated efforts exist in the private sector; however, they primarily benefit the richer classes. Nevertheless, in Africa there are examples of community-organized group care of children, involving women's groups or political organizations, in newly developed urban areas and in agricultural areas. Depending upon the sociocultural setting, other approaches are being developed. They include organized systems of day-care in factories or industrial facilities, neighbourhood centres, cooperative self-help women's groups, and family-based day-care facilities for children of working parents in which older members of the family take part.

94. School health. While in the past the emphasis was on routine health examinations of schoolchildren, school health now concentrates on motivating children to develop healthy habits for their lifelong health. In addition, schoolchildren join in learning about health problems of their community as a whole, and in carrying out selected health activities for themselves as well as for other children and their families. Schools can effectively carry out specific activities such as updating of immunization, nutrition education, accident prevention, and screening for hearing and eyesight problems. The training of schoolteachers and other school employees to give health guidance is being increasingly emphasized by organized educational systems.

95. However, in areas where school attendance is low, and where the social environment is poor, the health needs of school-age children who do not attend school are likely to be more acute than those of children in school. Moreover, it is estimated that by 1985 the number of children who receive no formal schooling whatsoever will have increased considerably.

96. Services for adolescents. Adolescents in most of the world are served through normal health services channels, or through special services such as school health services, though the latter do not exist in most areas for this age group. Innovative types of services for adolescents have been developed, mostly in urban centres in industrialized countries; these services are usually provided through nongovernmental or voluntary systems of care, and have very limited coverage. They are also geared chiefly to special problem groups, including adolescents with problems related to drug addiction, juvenile delinquency, and teenage pregnancy.

97. Social legislation. During the past decade many countries, both developed and developing, have enacted legislation that upholds the right of individuals with respect to the availability of necessary services. International labour conventions governing maternity leave, flexible hours so that a mother may breast-feed her child, and the provision of day-care facilities for young children have now been implemented in almost all developed countries and some developing countries. In a few countries in Europe, for example, social legislation adopted in recent years enables mothers in outside employment to stay at home with full or partial pay for a year or more in order to care for a child. Legislation in one country allows for the mother or father to stay at home for the first eight months of the child's life. Furthermore, legal developments since 1967 reflect a change in attitudes towards abortion and family planning. In an increasing number of countries legislation now focuses on

the rights of women as well as the health conditions and social welfare of women and their families as an indication for the provision of family planning services and the lawful termination of pregnancy.

98. Workers' health. Recent studies have shown that occupational conditions for women are often poor, with specific and serious effects on their health, particularly in relation to complications in pregnancy. Several types of industrial pollution have been shown to have deleterious effects on fetal development.

99. In conclusion, it is clear that for MCH care to be effective, it must be adapted to the life-style and socioenvironmental conditions in each area or country, and planned to meet the specific needs of the populations concerned. The positive examples which are found on either a regional or national scale are convincing enough to indicate that it is possible to provide MCH care for many populations in the world which are now deprived of such care.

VII. PRIORITIES IN MCH FOR THE YEAR 2000

MCH and primary health care

100. Within the primary health care approach, as the key for reaching the goal of health for all by the year 2000, the crucial importance of MCH can hardly be over-emphasized. The basic principles underlying the overall strategies and policies for primary health care are fundamental to the concepts of MCH care: the intersectoral approach; the need for total coverage; the participation of individual families and communities; the maximum use of existing resources such as traditional birth attendants, women's groups and schoolteachers; and so on.

101. As the major and essential part of action for maternal and child health takes place within the family, the emphasis of MCH care within the health care system - specifically, primary health care - must be to support community and family self-reliance, especially regarding the family's responsibilities in child-bearing, child-rearing and self-care.

102. Several conclusions can be drawn about MCH care within the health system:

- MCH care at the primary level benefits from the involvement of often untapped local resources, which include traditional practitioners such as traditional birth attendants.

- Local strategies of MCH care are needed to meet local needs and problems. The rationalization and use of resources and the content of care have to be defined within the community itself.

- MCH care must concern itself with the direct and indirect causes of morbidity and mortality, which include the type of social organization, the values and aspirations and the particular problems that characterize and influence the lives of families.

- MCH care must achieve total coverage, to ensure that a continuity of care is accessible to all women and children, including the systematic identification of those at greatest risk and the provision of referral care.

- MCH care includes preventive, promotive, curative and rehabilitative aspects of health care for mothers and children; this integration is the most efficient, effective and acceptable form of care, from the point of view both of the people themselves in terms of their time, understanding and use of services, and of the rational utilization of resources.

- Health care of mothers and children cannot be considered in isolation from other aspects of the health sector or from other sectors of development, both formal and informal. Intersectorial approaches include the linking of MCH care with formal and nonformal educational systems, day-care facilities, social legislation, and women's organizations.

- MCH care should be planned and implemented as part of the overall health care system and within the overall development plans.

MCH actions

103. For MCH care, considered as part of the primary health care approach, the knowledge and technology to reduce greatly the rates of death of mothers and children, alleviate their suffering, and contribute to the quality of life of all throughout the world are available now. Quantifiable targets can be set by each Member State and the effectiveness of programme activities can be monitored through the use of suitable indicators. Of the major health problems of mothers and children, a large proportion could be prevented through the application of specific technologies already well-known. Some examples follow:

- Maternal deaths could be brought to within a range of 1-3 per 10 000 births in all parts of the world. Complications of pregnancy and childbirth could be reduced through: prenatal checks for every woman, to identify those who need extra care; nutritional supplementation when required, including iron; attendance during delivery by a person trained in appropriate techniques.

- Births can be spaced and timed, with advantages for maternal and infant health. The information, and many effective methods, exist to regulate the timing and spacing of pregnancies. These could be available to all couples at low cost. The means for choice could be within the reach of all.

- The incidence of low birth weight could be reduced to not more than 10% in all parts of the world. The third trimester of pregnancy is of particular importance for the weight gain of the fetus. Alleviating the high-energy consuming tasks of women and increasing the energy intake in the third trimester could raise birth weights greatly, and contribute to reductions in infant mortality. Families and communities could do much to help and governmental support could be provided, through such measures as maternity leave and child benefits. All members of society must share these responsibilities.

- Neonatal tetanus could be eradicated in all societies. Immunization of women twice before the birth of the baby is sufficient to prevent neonatal tetanus. This could become the next worldwide success following the eradication of smallpox.

- Vitamin A and D deficiency diseases could be abolished. The scientific knowledge for preventive actions has been known for over half a century. If all channels of communication were used to convey the information and nutritional supplementation was provided where needed, the sufferings caused by these deficiencies - the blindness and deformities - could be eliminated. With a concerted effort, this goal could be achieved.

- Deaths due to diarrhoeal diseases could be reduced significantly. The immediate application of the oral rehydration treatment could save millions of lives, giving young children a chance to survive the crucial weaning period. It can be administered within the family, thus greatly facilitating widespread use.

- Death and disabilities due to childhood diseases could be avoided. Systematic immunization against diphtheria, pertussis, tetanus, tuberculosis, measles and poliomyelitis can effectively reduce the incidence of these diseases.

104. The Member States of WHO have set the target of immunizing all children of the world by the year 1990,[1] while the United Nations Water Conference (1977) set the goal of safe water supply and sanitation for all by 1990. Exactly what impact these will have on infant mortality is not known. However, it is clear that in order for the impact to be significant, they must be accompanied by other essential elements of MCH care, including a substantial improvement in nutrition.

[1] Resolution WHA31.53.

105. Other components of MCH care are more complex by the very nature of the problems and solutions; they require time for people to absorb information and change behaviour. Some examples are given in the following paragraphs.

106. Prevention of accidents. Accidents are of concern to both developed and developing countries. Because they are the dominant cause of death of children over 4 years of age in many countries, a declining rate must now be aimed at. The health care system can give the diagnosis but must convince other sectors of their roles in preventing this "man-made" disease.

107. The promotion of infant and young child nutrition. The promotion of breast-feeding is fundamental to preventing malnutrition in infancy, as is the control of the introduction and use of artificial infant food. The use of locally produced, nutritionally and culturally acceptable foods during the weaning period is essential. Knowledge about the dietary needs of children, including the timing of meals and form (density) of the foods, can be conveyed to people. Simple growth charts[1] to measure the growth of children exist and can be kept by mothers.

108. Education. Knowledge about health and its determinants, and preparation for parenthood, should become part of general education, through formal and informal educational programmes, the mass media, etc. Information on the behavioural and psychosocial aspects of child development can help to prevent many mental health problems at later stages. Increased knowledge and information are essential for people to improve their own health. Education of the public in health costs little compared to the high price of ill-health.

109. Social legislation. The fact that women have a unique role in the creation of a new generation must not lead to the assumption that the whole responsibility should lie with them. There is no reason why women should carry the main burden, as well as paying the price of higher mortality, more ill-health, lesser opportunities in the labour market, or less pay. Men are partners in more than a biological way, and the duties and joy of caring for and being with children surely belong to both men and women. The future generation is the responsibility of society as a whole - men and women, parents or not - to create the best possible conditions for the growing generation.

110. Training strategies for MCH care.[2] Strategies should be oriented to ensure that the training is socially relevant and addresses itself to the three main groups involved in MCH care: (a) families, communities and the public at large; (b) workers in various development sectors, including policy-makers and planners; and (c) the different categories of health workers at all levels, including primary health workers, health auxiliaries, traditional birth attendants, and health professionals and specialists working at supervisory and referral levels.

111. Health research. As already noted, certain areas of MCH require new knowledge and appropriate technologies. In general, however, to meet the priority needs in MCH, much is already known. In the years to come, the major research efforts will have to be geared to the application of this knowledge, with emphasis on health service research.

112. In summary, there are a number of prerequisites to be met if the present health situation of mothers and children is to have any chance of being rectified: a firm political will and supportive social organization; an increased budget for health with an objective and rational allocation for maternal and child health; birth registration and appropriate indicators for MCH; the whole health care system supportive to peripheral levels and the "have-nots"; and measurement of the health service against its impact on the health problems of the population.

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[1] World Health Organization. A growth chart for international use in maternal and child health care: Guidelines for primary health care personnel. Geneva, 1978.

[2] See Training in maternal and child health (document JC22/UNICEF-WHO/79.4), submitted to the UNICEF/WHO Joint Committee on Health Policy, twenty-second session, January 1979.

VIII. WHO'S ROLE IN THE PROMOTION OF MCH

113. In recent years, in line with the primary health care approach, Member States have committed themselves to renewed attention to MCH. This is reflected in the work of the WHO regional committees. For example, the Regional Committee for Africa will observe the twentieth anniversary of the United Nations Declaration of the Rights of the Child at its 1979 session. As part of comprehensive health services and with its emphasis on primary health care, MCH is given high priority in the African Region. In 1976, the XXIV Meeting of the Directing Council of PAHO (also the twenty-eighth session of the WHO Regional Committee for the Americas) adopted resolution XXXIII on health and youth as a priority for the Region. Also in 1976, the Regional Committee for South-East Asia recommended (resolution SEA/RC29/R8) that special attention be given to the problems of child care in the Region, with particular emphasis on nutrition and family welfare. The Regional Committee for Europe will discuss the medium-term programme for maternal and child health in 1979.

114. In 1976, the Regional Committee for the Western Pacific adopted resolution WPR/RC27.R14 according first priority for the regional programme to the objectives in section 10.3 of the Sixth General Programme of Work relating to the promotion of family health, particularly maternal and child health. Subcommittee A of the Regional Committee for the Eastern Mediterranean, after the 1978 Technical Discussions on the present state of child health in the Region, urged governments to increase their efforts in this field, fix targets to be attained in the next 10 years, and determine strategies and allocate resources to achieve these targets (resolution EM/RC28A/R.13).

115. As part of the Sixth General Programme of Work, WHO has strengthened its activities to support national programmes in MCH care. The Organization's MCH support programme has evolved over the past few years to become more relevant to countries' priority needs and to promote national self-reliance. The activities fall within the major programme of Family health, which appears in the programme classification as part of the Development of Comprehensive Health Services. The objectives of the Family Health programme are:

- to promote family health, in particular to foster optimal physical growth, the psychosocial development of the child, improved reproductive health, and an enhanced quality of life;

- to support technical cooperation with and among Member States in developing and strengthening the family health component of the overall health system;

- to promote intersectoral development strategies for improving the health and social wellbeing of women, children and the family as a whole.

116. Furthermore, as part of the Family Health programme, the Organization's MCH activities are carried out together with those in Nutrition, Health Education and the Special Programme of Research, Development and Research Training in Human Reproduction. The MCH activities are also closely linked with other programmes such as diarrhoeal diseases control, the Expanded Programme on Immunization, Mental Health, and Health Manpower Development. WHO works in close collaboration with the other United Nations bodies, bilateral agencies and nongovernmental organizations concerned, in particular UNICEF, UNFPA, FAO, UNESCO, the International Children's Centre, the International Pediatric Association, and the International Planned Parenthood Federation.

Technical cooperation with and among countries

117. WHO's present MCH programme is described in the proposed programme budget for 1980-1981 (Official Records No. 250, pp. 143-146) being reviewed by the Thirty-second World Health Assembly.

118. At the country level, WHO supports more than 70 countries in the development and strengthening of the MCH component of their health care systems, especially as part of primary health care. Activities are carried out for the development of methods to improve national

MCH programme management, including planning and evaluation, information and records, and approaches to the development of strategies which form part of the overall development of plans for primary health care. For example, health services research in MCH includes the development of the risk approach for MCH care referred to earlier. Research is also initiated in countries to assess technologies now used in MCH, with a view to their adaptation and use in the home or by village health workers, and to identify areas where new technologies need to be developed. These activities promote the application of the specific interventions mentioned in section VII. In the development of human resources, WHO supports the systematic building up of national capabilities to meet the needs of the MCH programme of each country, within the country. Activities are mainly oriented to the training of teachers of workers in MCH at the community level, including both health personnel in the health system and others such as traditional birth attendants, schoolteachers, and members of women's groups.

119. With the endorsement of the UNICEF/WHO Joint Committee on Health Policy at its twenty-second session in January 1979, WHO is now extending its collaboration with UNFPA and UNICEF to include, among other activities:

- identification and strengthening of existing national and regional institutions involved in various aspects of maternal and child health, in particular national research, development and training centres, and support for the development of such new institutions where required;

- support of the development of suitable national mechanisms to ensure closer integrated planning and implementation of programmes in all sectors related to MCH care as part of comprehensive national health systems, and relevant training and research.

120. In addition, technical cooperation among countries is facilitated through regional and global support by the Organization. The synthesis of knowledge and exchange of technical information on MCH is an important aspect. Based on the latest available knowledge, information is collected, distilled, analysed, synthesized and disseminated among countries. Regional and national centres, especially those in developing countries, are involved in the process. This includes activities related to support to management aspects of MCH care, as well as priority health issues such as the physical growth and psychosocial development of children; infant and young child nutrition, including breast-feeding; appropriate technologies for perinatal care; the epidemiology and social implications of low birth weight; and reproductive health in adolescence. Technical guidelines are also being prepared for workers in other sectors, including actions for promoting the equitable participation of women in development, for new approaches to the day care of children, for school health, and for social support measures for the family.

121. In resolution WHA31.55, the Director-General was requested to "proceed with the preparation of a WHO medium-term programme for maternal and child health". This is being done through the preparation of the family health component of the medium-term programme for the development of comprehensive health services; a planning meeting took place in April 1978 in the African Region and, following a meeting to be held in June 1979 in the South-East Asia Region, this medium-term programme is to be finalized with the participation of WHO secretariat and national staff. It will then be submitted to the Programme Committee of the Executive Board in November 1979.

International Year of the Child (IYC), 1979[1]

122. On the occasion of the IYC, WHO has taken the opportunity to draw greater attention to MCH programmes and, in addition, a number of specific activities are being undertaken. Many national groups, international agencies and nongovernmental organizations, together with WHO, have initiated mechanisms for concerted efforts to promote and strengthen continuing and long-lasting action for investment in childhood. Within this overall context, mention may be made of a series of regional and interregional seminars, workshops, and meetings being held to further the objectives of the IYC.

[1] The International Year of the Child and WHO, WHO Chronicle, 33: 3-6 (1979).

123. As part of the Year of the Child, WHO has cooperated with Member States in the setting up of IYC national commissions to plan immediate and long-term action for children. Such commissions which now exist in almost all countries, developed and developing, have multidisciplinary and multisectoral representation, including the participation of nongovernmental or voluntary organizations. The IYC is an opportunity for the health sector to take decisive steps in contributing to the social development of the nation. The commissions are important forums for exerting social pressure for the reallocation of resources, which would make the investment in childhood a reality. For many countries, they may be the first bodies that can effectively bring about comprehensive planning within the context of national development. These commissions can serve as an important entry point for the development of intersectoral plans, including the formulation of national policies, strategies or plans of action for primary health care in order to attain the goal of health for all by the year 2000. In this regard, WHO can play an important role in supporting national health authorities to strengthen overall development planning and programming for the health and wellbeing of children. WHO can also, in support of technical cooperation among developing countries, bring together representatives of IYC commissions from various countries, so that experiences and ideas can be exchanged, and common issues can be discussed with a view to collective action.

124. In summary, it is proposed to strengthen WHO's support to national efforts in the promotion of maternal and child health as part of primary health care and overall development through:

- reinforcing and increasing technical cooperation with countries and facilitating cooperation among countries, including support of national and/or regional research, development and training institutions in MCH as part of centres for health development. This could include creating mechanisms for the twinning of institutions between developing countries as well as between developing and developed countries, both for setting up new institutions and for strengthening existing ones.

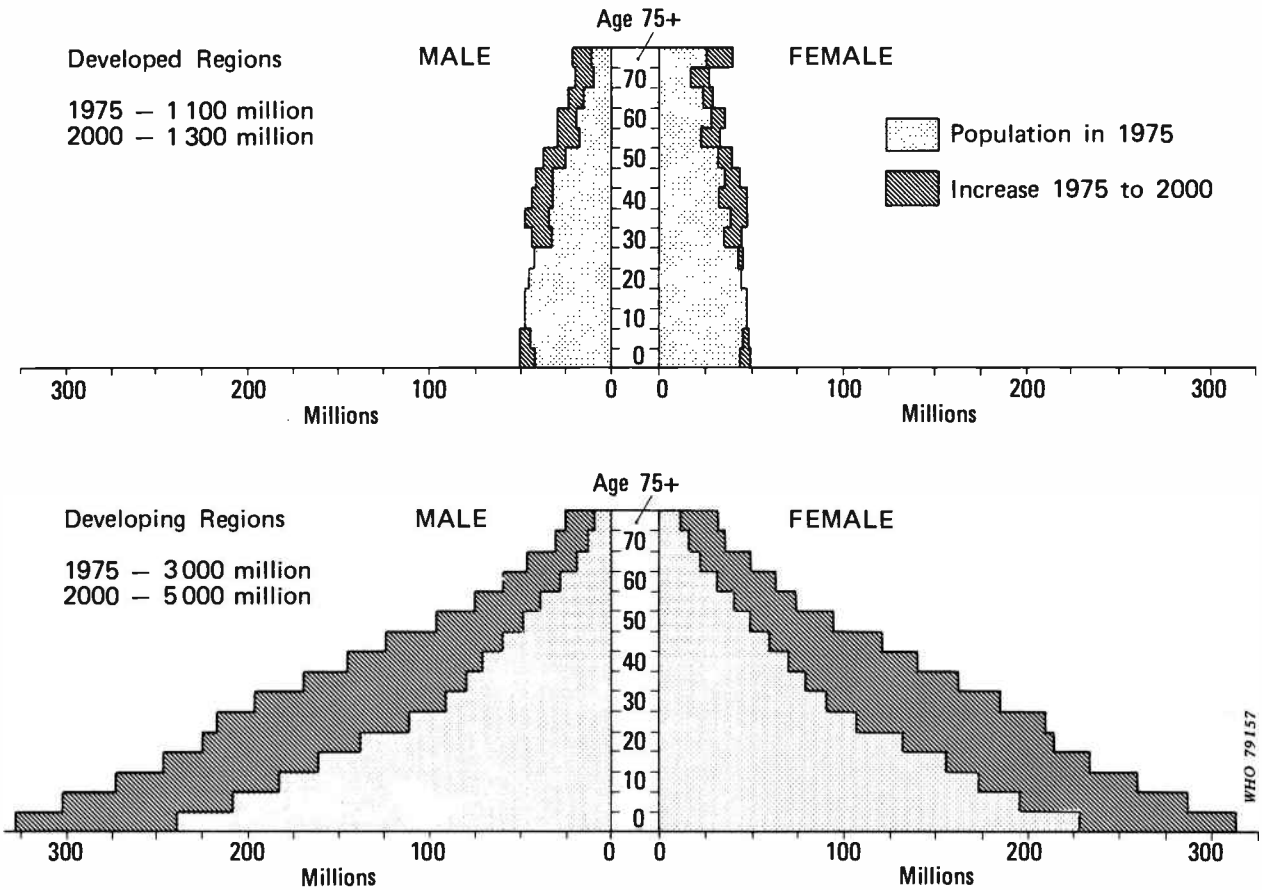
- the promotion of intersectoral development programmes which will ensure closer integrated planning and implementation of programmes related to MCH care as part of national health systems and of comprehensive national plans for overall development. This involves WHO, with UNICEF, playing a catalytic role in the formation and functioning of national coordinating committees to promote an adequate investment in children, including MCH as part of primary health care.

- the synthesis and dissemination of information concerning priority issues in MCH which is relevant and appropriate for national action. This includes information for policy-making at national and community levels in all sectors, for management of health and other development programmes, and for communities and families, to permit effective participation in sustained action to benefit children.

125. In response to United Nations General Assembly resolution 31/169 of December 1976, UNICEF will be preparing a comprehensive, action-oriented report, concerned with the projects and programmes initiated by governments and specialized agencies in connexion with the IYC and on the follow-up activities foreseen for the years ahead. Member States and WHO should not miss the opportunity to make a positive and forceful contribution to this plan of action for the benefit of children in the context of the formulation of national, regional and global strategies for the attainment of an acceptable level of health for all by the year 2000.[1]

[1] See Annex 2.

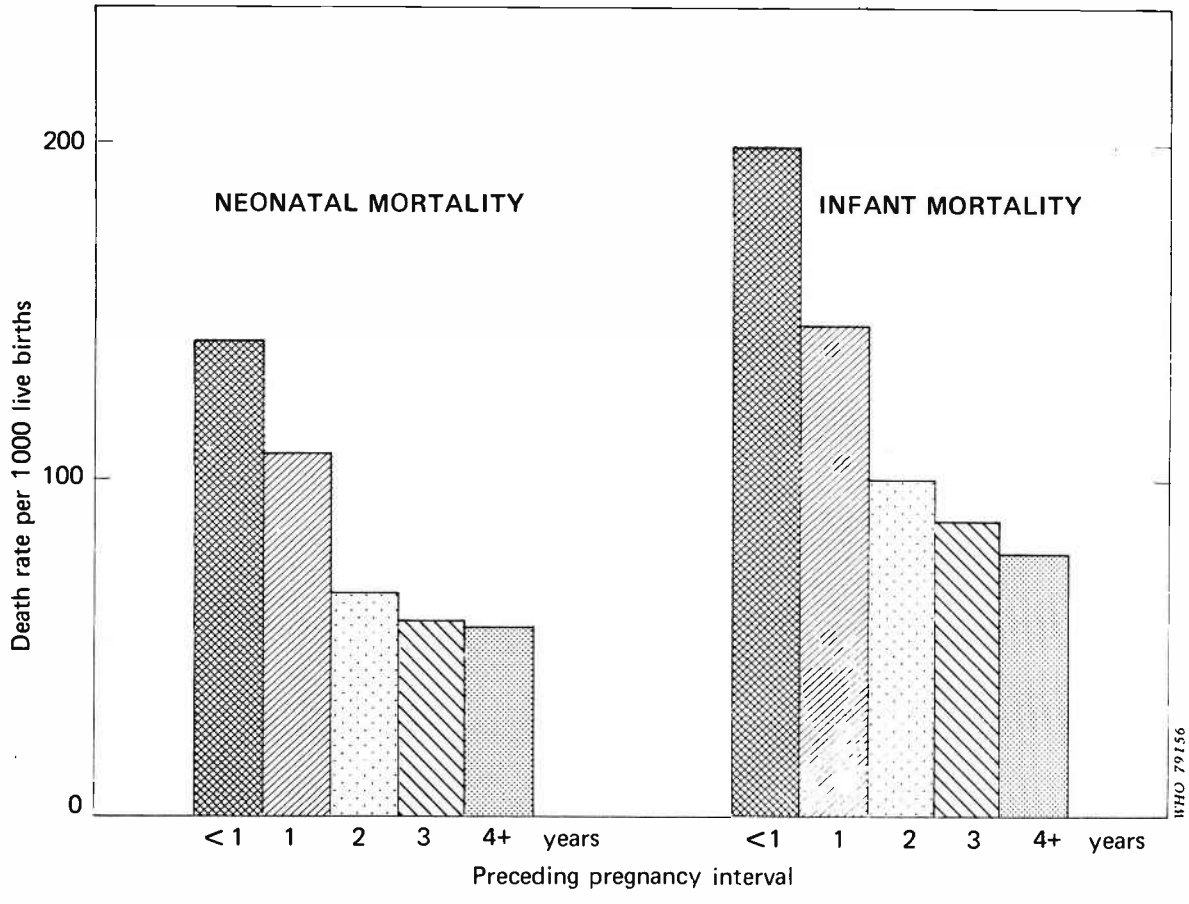
FIG. 1
POPULATION BY AGE AND SEX (1975 AND 2000)



Source: Data from United States Bureau of the Census; published in Department of State Bulletin, October 1978.

FIG. 2

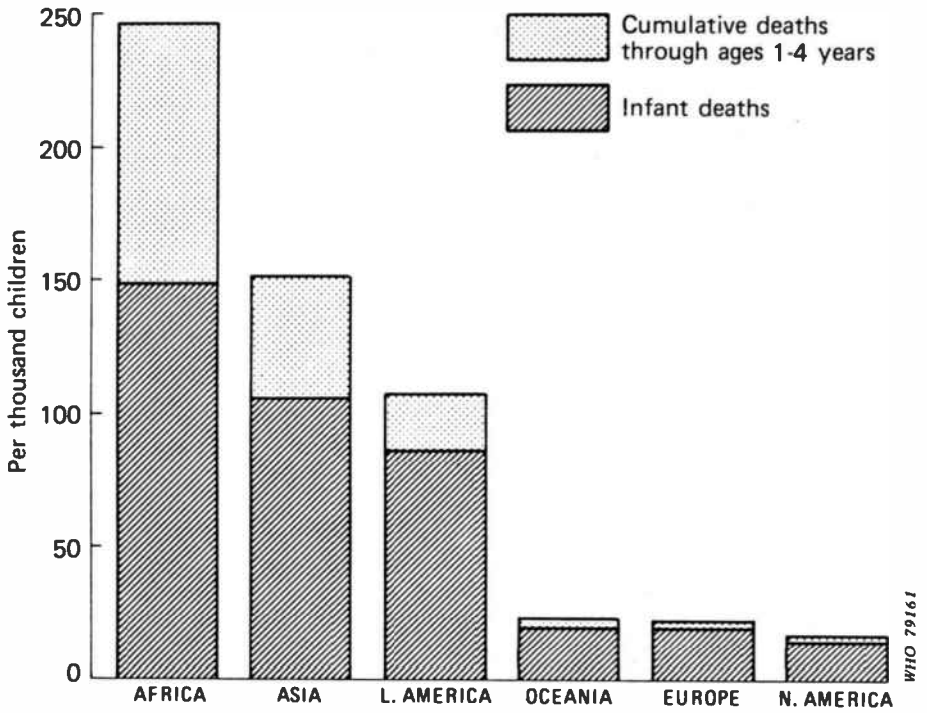
THE EFFECT OF PREGNANCY SPACING ON NEONATAL AND INFANT MORTALITY



Note: Preceding pregnancy interval = the interval between the termination of the preceding pregnancy and the birth of the infant.

Source: Omran, A. R. & Standley, C. C., ed. Family formation patterns and health. Geneva, World Health Organization, 1976, p. 215 (data from South India sample, 1971-1975, 6541 women).

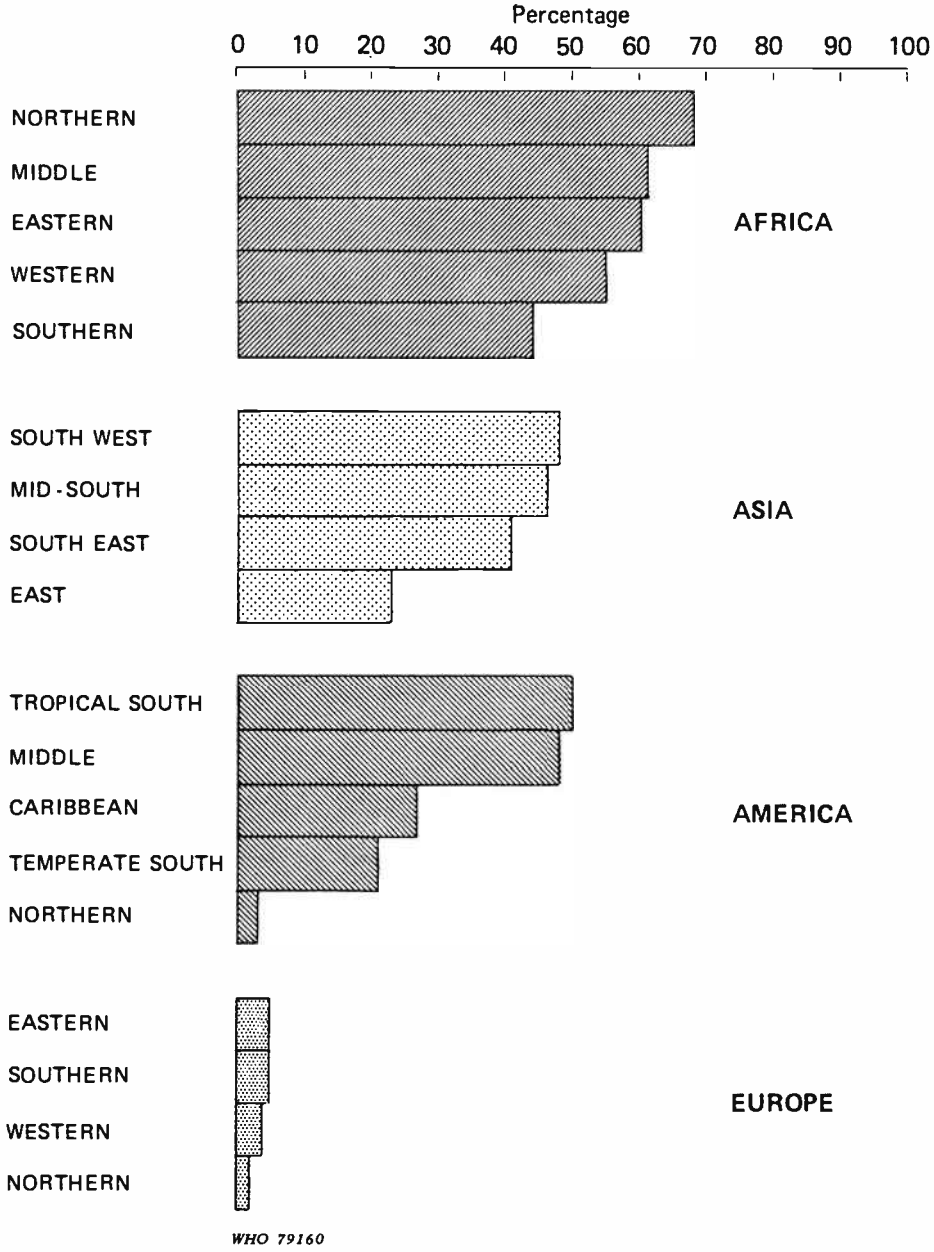
FIG. 3
PROBABILITY OF DYING BEFORE THE AGE OF 5 YEARS
IN MAJOR REGIONS



Note: WHO (Division of Family Health) estimates based on data from various sources.

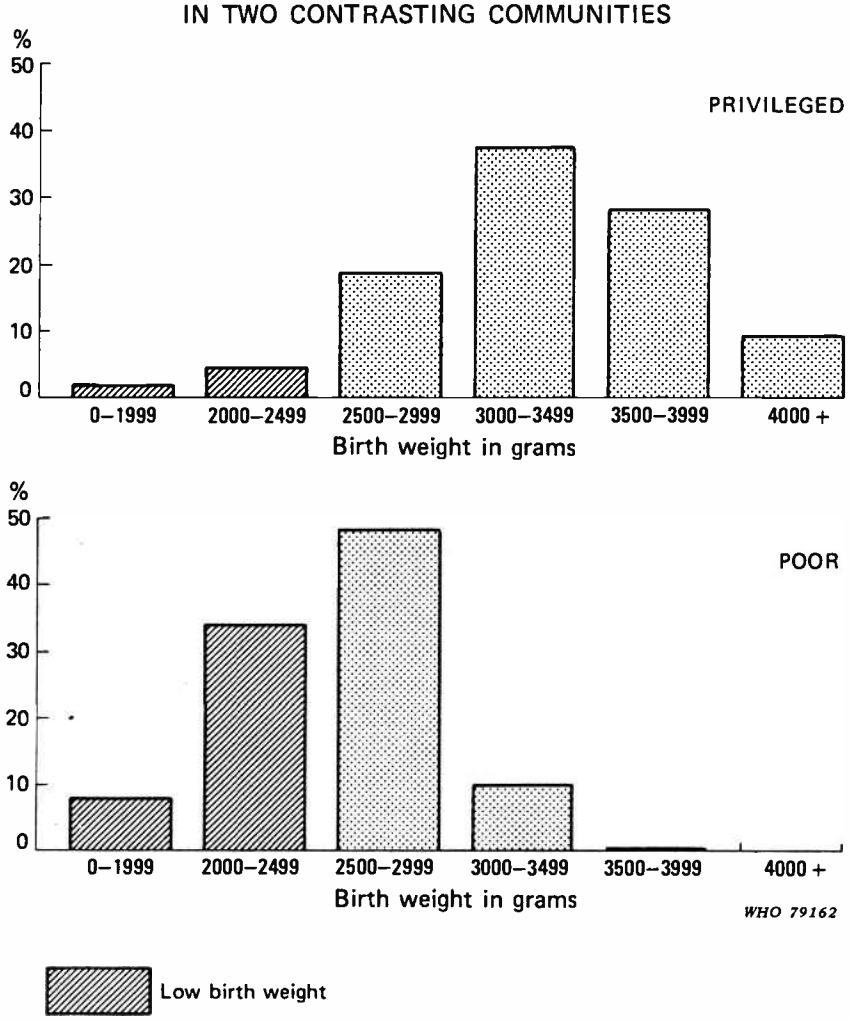
FIG. 4

DEATHS OF CHILDREN AGED UNDER 5 YEARS AS A PERCENTAGE OF DEATHS AT ALL AGES



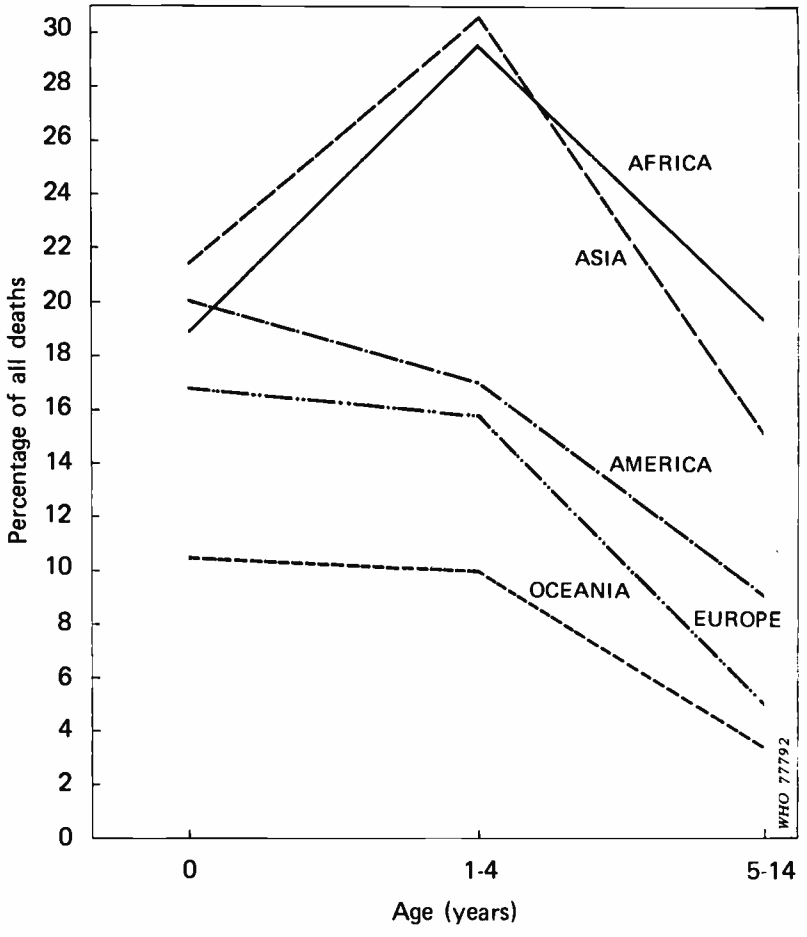
Note: WHO (Division of Family Health) estimates based on data from various sources.

FIG. 5
DISTRIBUTION OF BIRTH WEIGHTS OF INFANTS
IN TWO CONTRASTING COMMUNITIES



Source: Based on data presented to a workshop on birth weight - A novel yardstick of development, organized by the Swedish Agency for Research Cooperation with Developing Countries and WHO, Sigtuna, Sweden, 16-18 June 1977 (see SAREC report No. R: 2, 1978).

FIG. 6
DEATHS DUE TO ACUTE RESPIRATORY INFECTION



Note: Data show deaths due to acute respiratory infection as a percentage of deaths from all causes in the period 1970-1973.

Source: Bulla, A. & Hitze, K. L. Acute respiratory infections: a review. Bulletin of the World Health Organization, 56: 481-495 (1978).

ANNEX 4

REPORT OF THE DIRECTOR-GENERAL ON THE WORK OF WHO IN 1978[1]

/A32/2 - 30 March 1979/

CONTENTS

[1] See decision (11).

Introduction

1. 1978 will be remembered for a long time in health and related circles as the year of Alma-Ata. The Alma-Ata Declaration crystallized years of evolution of new health policies that are aimed at bringing about the sweeping health reforms required to attain an acceptable level of health for all the people of the world in the foreseeable future. The International Conference on Primary Health Care[1] that was held in Alma-Ata, USSR, was a manifestation of the collective aspirations of the people of the world for a better level of health, based on the well-founded belief that the socially just application of existing knowledge would suffice to ensure a level of health that would permit people throughout the world to live socially and economically useful and satisfying lives.

2. What does the Alma-Ata Declaration symbolize politically? If governments accept it with only a fraction of the enthusiasm with which participants at the Conference adopted it, this will imply their readiness to make political commitments to adopt primary health care and to act in a spirit of international solidarity to attain the objective of health for all by the year 2000. It will be an expression of their readiness to address themselves seriously to the existing gap in the levels of health of people within countries and among countries, and to adopt concrete measures to reduce this gap. It will thus signify their consent to make preferential allocations of resources for health to the socially underprivileged as an absolute priority. It will denote their agreement to ensure the proper planning and implementation of primary health care in coordinated efforts of the health and relevant sectors, in order to promote health as an indispensable contribution to the improvement of the quality of life of individuals, families, and communities and as part of overall socioeconomic development. It will illustrate their willingness to mobilize and enlighten individuals, families and communities in order to ensure their full identification with primary health care, their participation in its planning and management, and their contribution to its application. It will manifest their intention of introducing the reforms required to ensure the availability of relevant manpower and technology, sufficient to cover the whole country with primary health care within the next two decades at a cost they can afford. It will be an expression of their determination to introduce, if necessary, radical changes in the existing health delivery system so that it properly supports primary health care. It will testify to their commitment to fight the political and technical battles required to overcome any social and economic obstacles and professional resistance to the universal introduction of primary health care.

3. But the year's activities were not confined to political declarations alone; they were accompanied by political action. The Alma-Ata Conference was preceded and immediately followed by action to intensify the image of health development on the world political scene. At the Thirty-first World Health Assembly, in May 1978, an appeal to the political leaders of the world was launched to make the target of health for all by the year 2000 the social target of governments in the last quarter of the twentieth century. This was followed up by personal appeals to these same leaders. The response was encouraging, and served to indicate the need to persist in this process of political persuasion for health.

4. In the regions, these efforts, which have become known as the political struggle for health, were taken up by the regional committees. In individual countries, Ministers of Health approached their heads of state to impress on them the opportunities offered by using health as a lever for social and economic development and a synergist of efforts for peace.

5. Parallel to these political drives, the Executive Board took practical measures to respond to the call of the International Conference on Primary Health Care for urgent national and international action. The Declaration of Alma-Ata had called on all governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors, as the key to attaining an acceptable level of health for all. The Board identified essential issues and defined guiding principles for the formulation of these strategies. The preliminary document of the Board on this matter[2] will be discussed by the Thirty-second World

[1] See also paras 80-91.

[2] See Annex 2.

Health Assembly in May 1979. The Board has recommended to the Assembly that it invite Member States to take urgent action, individually to prepare national policies, strategies and plans of action, and collectively to prepare regional and global strategies in support of national strategies and plans of action.

6. In the heat of these developments, it is liable to be forgotten that 1978 was the first year in which the Sixth General Programme of Work came into force. This Programme was prepared collectively by the Member States of WHO. It is clear, if only from the above review of the International Conference on Primary Health Care, its precursors and its aftermath, that Member States are facing in a determined fashion through their collective action the health challenges for 1978-1983 that are mentioned in the Sixth General Programme. The extent to which Member States individually are using this Programme, on which they decided collectively, is not so clear. This relates both to health development in their own countries in accordance with the principles and objectives of the Sixth General Programme, as well as to technical cooperation between them and WHO in the implementation of the Programme.

7. It is useful to review the major areas of concern of the Sixth General Programme of Work with particular reference to the corresponding action of the Organization's governing bodies, since the deliberations and resolutions of the regional committees, Executive Board and World Health Assembly reflected some of the most important developments that took place in the course of the year. This approach has therefore been adopted throughout the report.

8. The experience gained with the translation of the Sixth General Programme into more detailed medium-term programmes - and the Secretariat was extremely busy in this connexion throughout 1978 - points to the need to learn more about how the Programme can be used by Member States as a framework for working together towards attaining the common health objectives that they defined in the regional committees and the Health Assembly. This is no reflection either on the work of the Secretariat or on Member States; it is intended to draw the attention of both to the need to ensure that Member States are fully involved in implementing this Programme throughout the period it covers, just as they were in formulating it. Member States were involved in preparing medium-term programmes for mental health and for health manpower development based on the Sixth General Programme of Work. These programmes were reviewed by both the Executive Board and the Health Assembly in 1978. Yet it is not clear to what extent they will have a modifying influence on current practices. Will Member States take serious measures to apply the public health and social aspects of the programme of mental health, which calls for the integration of mental health efforts at all levels of health care, rather than confining their activities to hospital-oriented custodial psychiatry? Will they take practical steps to plan and train health manpower in response to their own health service needs? In the final analysis the usefulness of these medium-term programmes will depend on affirmative answers to these questions.

9. Mention has been made above of action taken with respect to primary health care as part of a comprehensive health service. An essential feature of such care which was considered by the Executive Board, the Health Assembly and the regional committees, is the use of appropriate technology for health. This implies technologies which are scientifically sound, adapted to local needs, acceptable to the community, maintained as far as possible by the people themselves in keeping with the principle of self-reliance, and capable of being applied with resources the community and the country can afford. Further, this technology has to be applied through well-defined health programmes delivered through a countrywide health system that is based on primary health care and on the support it receives from the other levels of the health system. Perhaps the term has come to be used too narrowly, thus giving the appearance of preoccupation with machines and gadgets. It is worth recalling that most of the work of WHO is related to the development or application of appropriate technology for health. Examples to illustrate this point are provided in the body of this report.

10. Biomedical and health services research is one of the most important means by which, inter alia, appropriate technology for health can be developed and applied. Outstanding progress was made during 1978 in broadening and deepening the Organization's activities for promoting and developing health research. This was particularly evident in the work of the regional advisory committees on medical research, as well as the global advisory committee and

the governing bodies. This progress symbolizes the increased participation of Member States and of the world scientific community in tackling problems of public health importance through concerted efforts. Thus the regional advisory committees on medical research defined regional health research priorities, and the global advisory committee, in close collaboration with the regional advisory committees, dealt with policy issues of global import such as health services research, the ethical aspects of research activities, research management, and the dissemination of scientific information. The global advisory committee assumed a coordinating function with respect to research on diarrhoeal diseases with a view to ensuring that activities in this field throughout the world are mutually supportive and that the results will be quickly applied wherever necessary.

11. The Special Programme for Research and Training in Tropical Diseases made rapid progress, and succeeded in attracting large funds from outside WHO's regular budget. The Special Programme now has to face the challenge of ensuring that these funds do indeed support its dual purpose - that is, to solve important health problems as far as possible within the developing countries in which they prevail with the full support of countries that have greater resources for health research; and, in so doing, to strengthen the health research infrastructure in these same developing countries so that they will ultimately become self-reliant in the research required to deal with newly emerging health problems.

12. The Special Programme of Research, Development and Research Training in Human Reproduction continued to attract large extrabudgetary funds. The remarks made in paragraphs 6 and 7 above concerning the use by countries of the Sixth General Programme of Work are also applicable to this Special Programme. Many national institutions are now involved in it, and governments have much to gain, from the viewpoints of both political wisdom and social relevance, by linking research in this field with their national policies for family health. Criticisms have been made in the Organization's governing bodies that more could have been done to investigate the reasons for the inadequate use of existing methods of fertility regulation. If certain Member States share these feelings, they could possibly do more to ensure that the research activities conducted in their country with funds from WHO's Special Programme correspond to their family health needs as identified by them. This would be to their own benefit and in addition could serve as an example to others.

13. During 1978 the Organization was particularly active in exploring ways of ensuring the availability of essential drugs to people everywhere. The Technical Discussions at the Thirty-first World Health Assembly, the subsequent Health Assembly resolution which launched the action programme on essential drugs, as well as resolutions adopted by a number of regional committees on this matter, all testify to this vigorous action. But the existence of an agreed short international list of essential drugs, and action by governments to establish national lists accordingly, will not in themselves bring drugs to the people. Science and technology in this field have to be accompanied by political, industrial, commercial, educational, legislative, and legal action. Some of this action has been initiated by the non-aligned countries as part of their action programme for economic development, particularly through technical cooperation among developing countries. UNCTAD, UNICEF and UNIDO are also playing their part. However, an optimally coordinated drive is not taking place, and nothing less will be needed if all the obstacles are to be overcome. WHO, especially through its regional committees, will have to be used to a greater extent as a clearing-house for reaching agreements on the selection of countries for drug and vaccine production and quality control. Problems deriving from commercial interests or national prestige will have to be resolved if regional self-reliance in essential drug and vaccine supply is to be reached.

14. Reducing the gap between decisions and action is no less urgent for malaria control. In May 1978 the Health Assembly expressed regret that most of the recommendations it had made in 1969 had not been adequately implemented. It repeated its confidence in a combination of political, social, economic and technical measures rather than sole reliance on residual insecticide spraying. The Health Assembly emphasized the judicious selection by each country of the combination appropriate to its epidemiological and socioeconomic situation. A number of regional committees expressed support for the revised strategy for malaria control. In the

Region of the Americas, the Regional Committee, faithful to its long-held views, reaffirmed that eradication is the goal of the regional malaria programme. In response to the Health Assembly's request to the Director-General "to review WHO's functional structures where malaria is concerned", the Organization has established a malaria action programme aimed at undertaking an effective drive with the goal of speedy control of the disease. Discussion on semantics concerning "control" and "eradication" must not be allowed to confuse the issue. What is important is that the flexible multidimensional approach adopted by the Health Assembly should be wisely and vigorously applied. The indecision about goals, and means for attaining them, that characterized the antimalaria programme between 1969 and 1978 must not be permitted to repeat itself.

15. Eradication is the goal of the smallpox eradication programme, but general conclusions about the feasibility of disease eradication cannot be drawn from the experience of smallpox alone. The factors involved in the spread of smallpox are quite different from those involved in the spread of most other communicable diseases of public health importance. Surveillance, containment and vaccination, complex as they are, proved to be measures that could be applied by the health service, provided communities were adequately involved. This is not the case with many other major communicable diseases, in particular the parasitic diseases, whose genesis, spread and control depend on a host of environmental and socioeconomic factors. It is highly encouraging to note that in 1978 no cases of endemic smallpox were detected. An isolated laboratory outbreak was quickly contained. Nevertheless, this outbreak points to the need for national and international self-discipline to ensure that the number of laboratories retaining variola virus is reduced to the minimum group of WHO collaborating centres, as agreed by the Health Assembly and the Executive Board.

16. Without sensational promises of eradication, the Expanded Programme on Immunization aims at providing immunization for all the children of the world by 1990. The Programme is making steady progress in a spirit of realism. One-time campaigns are attractive, but ultimately frustrating. For sustained effectiveness, there is no alternative to proceeding doggedly, using the best available vaccines, applying them through primary health care, training the operational and managerial staff required in a step-by-step manner, and, parallel to these efforts, conducting the necessary research to improve vaccines and the cold chain required to store and transport them.

17. Effective vaccines do not exist for most diarrhoeal diseases. The control of these diseases ultimately depends on improvements in environmental and socioeconomic conditions. Oral rehydration, however, offers a simple and effective method for saving the lives of infants at a low cost. Its use is one of the components of the major attack on diarrhoeal diseases that was launched by the Thirty-first World Health Assembly and echoed by a number of regional committees during 1978. Research is another essential component, and is being undertaken with enthusiasm. A note of warning is in place with respect to this research, so that it does not become too academic, and so that it pays sufficient attention to the control of those factors that make the spread of diarrhoeal diseases possible, that is, the intermediate factors between the causative organisms and physical agents on the one hand and affected individuals on the other.

18. Diarrhoeal disease in children is closely related to their nutritional status. The question of malnutrition was again discussed by the Thirty-first World Health Assembly, which adopted a further resolution on the matter. This resolution once more stresses the importance of breast-feeding and the maximum utilization of locally available and acceptable foods for the feeding of young children. But uneasiness persists that much remains to be done by the Organization, and indeed by the health sector as such, until they find their proper role in multisectoral efforts with respect to national and international food and nutrition policies and plans. Valid information is still lacking on the essential dietary elements required in various environments, for people in different age-groups and in different occupations. Conventional wisdom in this field is taken too much for granted, whether through inertia or through the continuing growth of the food industry in the developed countries.

19. The situation with respect to water and sanitation is clearer. Ensuring the availability of safe drinking-water and sanitation has been accepted as a legitimate preoccupation of the health sector, and as a consequence of WHO's efforts an adequate supply of safe water and basic

sanitation are being included as essential components of primary health care. The Health Assembly, in May 1978, put its stamp on the role of WHO and its individual Member States in connexion with the International Drinking-Water Supply and Sanitation Decade. Responsibility for the actual provision of water is a multisectoral matter in most countries, and this is mirrored internationally by the establishment of a multisectoral mechanism to coordinate the efforts in this field of the United Nations, UNICEF, UNDP, ILO, FAO, WHO and the World Bank. WHO was appointed as the servicing agency for the steering committee of this coordinating mechanism. The first consultative meeting, held in November 1978, was also attended by representatives of other agencies in the United Nations system, bilateral agencies, intergovernmental organizations and development banks. Thus, there are encouraging signs that governments, international organizations and bilateral agencies are beginning to respond with due determination to the challenge of reaching the target decided by the United Nations Water Conference of safe water supply and sanitation for all by the year 1990.

20. While giving greatest emphasis to the basic environmental needs of developing countries, the Organization has in no way neglected its other commitments for protecting the human environment. Thus, the Thirty-first World Health Assembly again emphasized the importance of evaluating the effects of chemicals on health. In the course of the year initial steps were taken to establish an international programme for this purpose, WHO acting as the planning and coordinating focus for a network of cooperating national institutions as well as other international organizations concerned.

21. Indeed, cooperation was the keynote of activities throughout the year. The Executive Board, the Health Assembly, and the Regional Committees for Africa, the Americas, South-East Asia, Eastern Mediterranean and Western Pacific all adopted resolutions aimed at reinforcing technical cooperation among developing countries for the promotion of health, including the establishment of regional and interregional mechanisms for developing and strengthening such cooperation. Technical cooperation in the field of health among developing countries will be the subject of the Technical Discussions to be held during the Thirty-second World Health Assembly in May 1979. All the ingredients are there, but so is the impatience for action. WHO finds itself in a delicate situation. To be over-active would be to negate the concept of technical cooperation among developing countries for health; to be under-active could jeopardize the immediate widespread application of the concept. Only the individual and collective action of Member States themselves can solve this dilemma. Only they can decide in which ways and to what extent they would like WHO to catalyse and support their cooperative efforts for health.

22. The same dilemma exists with regard to the managerial processes for national health development that WHO continued to support in 1978. Country health programming must remain a national process if it is to retain its political sting. At the same time WHO has responsibilities to ensure the availability to Member States of useful methods for planning, programming, budgeting, evaluating, and providing adequate information support to countries' health programmes and services. The Health Assembly insisted on these methods being devised and applied by WHO in a more integrated manner than has been customary in the past. In the final analysis, however, the use of these methods as an integral part of the health development process will depend on the way they are applied by Member States. If increasing numbers of countries have introduced country health programming, few if any have created the permanent mechanisms required to ensure the continuity of the process that is required, particularly in connexion with the formulation of strategies for attaining an acceptable level of health for all by the year 2000.

23. The comments made above on technical cooperation among developing countries and on country health programming illustrate the sensitive relationships that exist between individual Member States on the one hand, and WHO as a mechanism for the collective action of its Member States on the other. Much thought was given during 1978 to this question and to many other related issues as the Organization groped towards better ways of working in response to the newer needs of its Member States as expressed by them. It was in this context that the Thirty-first World Health Assembly, when considering the Executive Board's organizational study on WHO's role at the country level, particularly the role of the WHO representatives, requested the Director-General to re-examine the Organization's structures in the light of its functions. All the regional committees took appropriate action in this connexion at their 1978 sessions,

and the questions raised are in the process of being reviewed by Member States. Relevant action has already been taken to improve the Organization's ability to function even before the results of the study become available. Thus, for example, the Regional Committee for Africa has taken steps to strengthen its own role and to improve its methods of work; and in the Eastern Mediterranean Region a regional consultative committee has been established to advise the Regional Director on the policy and strategy for developing technical cooperation with countries of the Region, preparing the regional programme budget, and securing extrabudgetary resources.

24. It can be seen that 1978 was a very busy year for WHO, whose activities ranged from the consideration of broad policy matters affecting the health of the whole of the world's population over the next two decades, to the examination of its own functions and the corresponding processes and structures for fulfilling them. The report that follows summarizes an illustrative sample of these activities.

Policies for health

25. The year 1978 witnessed a continuation of the animated dialogue begun in recent years within the governing bodies of the Organization; in the heat of this dialogue the policies are forged which WHO and its Member countries pursue in order to raise the level of health of the world's peoples.

26. It is a matter of considerable satisfaction and encouragement that the governing bodies are now becoming increasingly involved in debating and exploring the possibilities for health action at the national, regional and global levels and are expressing their views in a forthright and unequivocal manner. The debates on health policies are not always easy and are at times even acrimonious, because there are frequently a number of possible solutions to a particular health problem and different views are held on which might be the best solution. What does matter is that a consensus is finally reached and that all concerned are fully committed to the decisions taken, so that the Organization and its Member States can proceed to concerted and coherent action on the health front.

27. During 1978 the governing bodies debated a very wide range of health topics. Information on some of these debates and decisions is given in the appropriate sections of this report. To illustrate the important policy decisions taken, Table 1 (page 118) lists some of the topics discussed by the Health Assembly and the Executive Board, and Table 2 (page 119) lists some of the main issues debated by the regional committees.

The political struggle for health

28. The year 1978 saw the launching of what was later termed "the political struggle for health". Following the adoption by the World Health Assembly of resolutions WHA29.48 in 1976 and WHA30.43 in 1977 on the principles governing technical cooperation with developing countries, there was a growing awareness that the attainment of health is not only a technical matter but requires the national and international support of and action by political bodies. This concept was reflected in the opening statement of the Director-General of WHO to the Thirty-first World Health Assembly in May 1978, which emphasized that health policy must be formulated and implemented in consultation with other sectors of government and society, taking account of social, economic and political factors as well as of technical and managerial factors.

29. The Director-General subsequently wrote to a number of political leaders of the world, appealing to them to adopt the Organization's goal of health for all by the year 2000 as the world social goal for the end of the twentieth century. In view of the favourable response, WHO is continuing its efforts to ensure that proper account is taken of health whenever general development policy is debated at the national or international level. Technical and managerial input are not enough: what is required is political conviction and will.

TABLE 1. SOME IMPORTANT TOPICS CONSIDERED BY THE EXECUTIVE BOARD AND THE HEALTH ASSEMBLY DURING 1978

Subject	Executive Board resolution (January)	Health Assembly resolution (May)
Organizational study on WHO's role at the country level, particularly the role of WHO representatives	EB61.R34	WHA31.27
Monitoring of the implementation of programme budget policy and strategy	EB61.R6	WHA31.31
Technical cooperation among developing countries	-	WHA31.41
Appropriate technology for health	EB61.R31	WHA31.34
Medicinal plants	-	WHA31.33
Nutrition	EB61.R33	WHA31.47
Human reproduction research	-	WHA31.37
Mental health	EB61.R28	WHA31.21
Essential drugs	EB61.R17	WHA31.32
Malaria control strategy	-	WHA31.45
Control of diarrhoeal diseases	-	WHA31.44
Smallpox eradication	EB61.R10	WHA31.54
Expanded Programme on Immunization	-	WHA31.53
Health hazards of smoking	-	WHA31.56
United Nations Water Conference	-	WHA31.40
Effects of chemicals on health	-	WHA31.28
Health manpower development	EB61.R27	WHA31.36
Biomedical and health services research	EB61.R36	WHA31.35
Managerial processes for health development	(EB61.R24, (EB61.R25, (EB61.R26, (EB61.R32	WHA31.43 (WHA31.10, WHA31.11, WHA31.12, WHA31.20)

TABLE 2. MAIN ISSUES DEBATED BY THE REGIONAL COMMITTEES IN 1978

Regional Committee for Africa
Monitoring the implementation of programme budget policy and strategy
Reviewing the Regional Committee's method of work and strengthening its role as the main forum for defining programme policies for health development
Bringing the boundaries of the Region into line with those of the Organization of African Unity
Introduction of Portuguese as a working language
Technical cooperation among developing countries
Drug policies and management
Social policy and health development in Africa [1]
Regional Committee for the Americas
Primary health care
Technical cooperation among developing countries
Antimalaria activities
Yellow fever control
Foot-and-mouth disease and zoonoses control
Sociocultural obstacles to delivery of health care
Extension of health services
The impact of drugs on health costs: national and international problems [1]
Regional Committee for South-East Asia
Primary health care
Traditional medicine
Antimalaria activities
Health information
Health manpower development
Charter for Health Development
WHO's structures in the light of its functions
Technical cooperation among developing countries
Expanded Programme on Immunization [1]
Regional Committee for Europe
Primary health care
Cancer
New areas requiring development - malaria, child health, chemical hazards in the environment
Health services research
Special Programme for Research and Training in Tropical Diseases
Investigation and control of rheumatic diseases [1]
Subcommittee A of the Regional Committee for the Eastern Mediterranean
WHO's structures in the light of its functions
Integration of health services and manpower development
Essential drugs
Involvement of multinational corporations in planning, design and administration of health facilities
Control of cholera and diarrhoeal diseases
Prevention of blindness
Technical cooperation among developing countries
Health of workers
Appropriate technology for health
The present state of child health in the Region [1]
Regional Committee for the Western Pacific
Health manpower development in relation to primary health care
WHO's structures in the light of its functions
Technical cooperation among developing countries
Research promotion and development
Antimalaria activities
Health of workers
Diarrhoeal diseases [1]

[1] Subjects of the Technical Discussions held during sessions of the regional committees.

30. This issue was brought to the fore in all the WHO regions in 1978; three regions are mentioned here to exemplify how the theme was taken up at regional level. The WHO Regional Committee for Africa, for instance, laid stress on the relevance of health activities in the struggle to achieve greater social justice for the least privileged. It took steps to strengthen its role as the main forum in Africa for defining programme policies for health development. The Regional Committee also urged Member governments to increase their national health budgets and appealed to the Organization of African Unity to adopt the social policy of health for all. The Regional Director participated in the Khartoum summit meeting of the Organization of African Unity, and WHO was invited to present a situation paper each year in future at this summit meeting. Close cooperation was also maintained with the national liberation movements recognized by the Organization of African Unity.

31. In December, the Regional Director for South-East Asia made an approach, on behalf of his own Region and the Western Pacific Region, to the Association of South-East Asian Nations, to explore the possibility of closer cooperation in the field of health among members of the Association and WHO, with a view to ensuring better coordination of the Organization's programmes with those of the Association.

32. In the European Region, relations between WHO and the Council for Mutual Economic Assistance were formalized in 1978 by an exchange of letters. Council representatives attended the meetings on extrabudgetary resources for health held in Geneva in November, when discussions were also held on steps that might be taken to further collaboration. The Council will in future be invited to send representatives to the Health Assembly and sessions of the Executive Board, as well as other meetings of interest.

Changing the way WHO works

33. If WHO is to fulfil its many tasks competently, its machinery must be geared to operate with minimum friction and maximum efficiency. For this reason, the structure of the Organization has in recent years been subjected to close scrutiny with a view to appropriate modifications. During 1978 the governing bodies continued this examination of various organizational questions as part of the process of streamlining WHO's structure to enable it to make its full contribution to the promotion of world health.

34. In January 1978 the Executive Board, considering a report on its organizational study on WHO's role at the country level, particularly the role of WHO representatives,[1] stressed the essential element of flexibility. The Board endorsed the need to reinforce the technical and managerial competence of WHO representatives, emphasized the role of WHO in promoting the new type of public health training recommended in the study, and recommended that the title of WHO representative be changed to that of WHO programme coordinator. The desirability of increasing the participation of national authorities in the work of WHO was stressed, and regional committees were invited to take full account of the implications of the study.

35. When the Health Assembly considered this study, it agreed to the above-mentioned change of title recommended by the Executive Board. The Assembly approved the other findings, conclusions and recommendations of the study, especially with regard to WHO's role in fostering national self-reliance in health matters through technical cooperation with countries in the planning, programming, implementation and evaluation of their health programmes.

36. The Assembly urged Member States to participate more in the work of WHO and in the formulation and implementation of the Organization's policies. The Director-General was asked to reinforce the managerial and technical competence of WHO programme coordinators and to change, as needed, their status and functions. Further trials with national coordinating committees and with the employment of national personnel as WHO programme coordinators and project managers were also recommended.

37. The Assembly finally requested the Director-General to re-examine the Organization's structures in the light of its functions, as recommended in the study, with a view to ensuring that activities at all operational levels promote integrated action. The crucial question

[1] WHO Official Records, No. 244, 1978, Annex 7.

that has to be asked is in what way and to what extent governments want WHO, and what kind of WHO they want. During 1978 all the regional committees set up ad hoc groups or subcommittees to carry out the study in the regions together with the Regional Directors.

38. During the year three meetings were held of the working group set up by the Executive Board to deal with its organizational study on the role of WHO expert advisory panels and committees and collaborating centres in meeting the needs of WHO regarding expert advice and in carrying out the technical activities of WHO. The working group interviewed senior members of the Secretariat, and some members of the group visited WHO collaborating centres and attended meetings of the global and two regional advisory committees on medical research. The group found it necessary to take into consideration WHO's total need for expertise and the means of securing it. An analysis was carried out of different WHO mechanisms for expert consultation and participation. By the end of the year the working group had produced an interim report, but it had become evident that the study, which is of fundamental importance to the Organization, would take longer to carry out than was originally envisaged. It was therefore decided to prolong the study by one year.

39. The conclusions of the organizational study just mentioned will, inter alia, influence the future approach to mechanisms for coordinating and conducting the Organization's research activities. In January the Executive Board examined a report by the Director-General on the development and coordination of biomedical and health services research. The Board approved the greater involvement of the global and regional advisory committees on medical research, the concept of special action-oriented programmes including research and training, and the promotion of health services research in the context of national and regional priorities.

40. When the Director-General's report on biomedical and health services research was presented to the Health Assembly in May,[1] it was pointed out that research activities were continuing to gain momentum, particularly in countries and at the regional level. As a result of the activity of regional advisory committees on medical research, the intensity with which the regions have expanded their research activities is fully in keeping with the emphasis on technical cooperation with and among countries for the promotion of socially relevant health programmes. There has been a substantial increase in research funds during the past few years, due to contributions from about twenty Member States to the Voluntary Fund for Health Promotion - mainly for the special programmes on human reproduction and tropical diseases.

41. The Health Assembly asked the Director-General to continue to pursue the Organization's long-term efforts to coordinate and promote research - especially fostering technical cooperation with and between research establishments in Member States and strengthening their research capability. Member States were urged to collaborate among themselves and with WHO in all the above respects.

42. In November the Programme Committee of the Executive Board examined a progress report by the Director-General on the same topic, submitted in accordance with the instructions of the Health Assembly. The report gave the historical background of research in WHO and highlighted a number of conceptual approaches, current trends and managerial methods. The Committee emphasized the challenge of linking fundamental and applied research and underlined the need to integrate WHO's research activities into a coherent whole. It paid special attention to the strengthening of national research capabilities for the fulfilment of programme goals. In the Committee's view, the fundamental requirement in this area was to design and develop a long-term research plan.

Programme budget policy and strategy

43. During 1978 the governing bodies did not, of course, confine themselves to examining the structure of WHO's machinery: they also reviewed the way in which the machinery works - that is, the way in which it is used to achieve the Organization's objectives.

[1] Document A31/15.

44. In November the Programme Committee of the Executive Board studied a report of the Director-General on monitoring of the implementation of the programme budget policy and strategy. The report provided up-to-date information on development and progress in reorienting the Organization's work towards increased, socially relevant technical cooperation with and among developing countries. The report provided selective illustrations of progress in this regard in different programmes and also covered the monitoring of budgetary and financial implementation.

45. The Programme Committee noted that discussions had been initiated in the six regional committees on mechanisms for more effective technical cooperation, and panels made up of nationals had been set up to formulate strategies for more effective technical cooperation not only among developing countries but also between developed and developing countries.

46. The Programme Committee took into account Health Assembly resolution WHA30.30, adopted in 1977, on the subject of programme budget policy, which went far beyond the 60% allocation to the country level proposed in resolution WHA29.48 and indicated ways in which the Organization could achieve more effective technical cooperation with developing countries: the promotion of regional health charters; the greater use of regional panels of experts, regional advisory committees on medical research and regional centres for training and research development; the setting-up of national health councils; the greater involvement of nationals in the work of WHO; programme development processes for use at country level, and especially country health programming; and the more rational use of extrabudgetary funding.

47. A regional health charter is one approach for ensuring at the government level that health is accepted as an important part of national and regional development policies. In March, representatives of nine countries in the South-East Asia Region finalized the draft of a Charter for Health Development, intended to accelerate the improvement of health in the Region by helping to secure an appropriate share of both national and international resources for this purpose. The Charter, which was given political impetus by a resolution of the Regional Committee for South-East Asia, reflects the recognition that health is a basic human right. Governments adhering to the Charter acknowledge that they must ensure for their people the highest standard of health that their resources will permit. The Charter affirms that health is both a means and a goal of socioeconomic development and that the highest priorities are the areas of primary health care, manpower development, the provision of safe water and sanitation, maternal and child health, communicable disease control and malnutrition.

48. An important aspect of a regional health charter is intersectoral health policy definition, and the creation of a national health council or coordinating committee is an analogous form of policy definition at the national level. A particular kind of multisectoral mechanism was established in the Philippines in 1978 when, in September, a Memorandum of Understanding was signed between WHO and the Government of the Philippines, creating the Philippines/WHO Health Development Coordinating Committee. The Committee will be responsible for assisting the Government and WHO in all aspects of the planning, coordination, implementation and evaluation of WHO/national collaboration, discharging a number of functions of a WHO programme coordinator,[1] which the Philippines does not have. It is composed of a Chairman representing the Ministry of Health and of representatives of the National Economic and Development Authority, three other Ministries, the University of the Philippines, and WHO. The Committee will be concerned with national health planning, identify priority areas for WHO/national collaboration, assist in medium-term programming, brief national delegates to WHO's governing bodies, and ensure the implementation of those bodies' recommendations at the national level. It is hoped that the activities of the Committee will promote national skills, national self-reliance and technologies appropriate to the country's resources, and the health, social and community development of the Philippines.

Greater involvement of nationals in WHO's work

49. Greater involvement of nationals in WHO's work is an essential part of the strategy for developing technical cooperation. The Executive Board's organizational study on WHO's role

[1] The new designation of WHO representatives, in accordance with resolution WHA31.27 (see also para. 34 of this report).

at the country level, particularly the role of the WHO representatives,[1] presented to the Health Assembly in May, concluded that "the function of liaison between WHO and the governments, hitherto performed by WHO representatives, could benefit from new approaches that would make greater use of national skills and resources". It also recommended that further experimentation should take place with the use of national personnel as WHO representatives and project managers.

50. The Board felt that a number of advantages would accrue from the increased involvement of nationals in the work of WHO in their own country: they would, for instance, be able to facilitate the exchange of information, promote direct contacts between WHO and the health and other ministries, and ensure the relevance of WHO programmes to the countries' needs. Some problems can be expected to arise in connexion with the details of financing (such as the levels of remuneration of nationals working with WHO compared with the prevailing level in the particular country) and the definition of working relationships among the participants. For this reason, such arrangements should be flexible and firmly under the control of national authorities.

51. These new initiatives, which include the use of national coordinators for the work of WHO and the recruitment of nationals to act as managers of national programmes in which WHO is collaborating or as support staff in the offices of WHO programme coordinators,[2] are currently being tested in some regions of WHO, as is illustrated by two examples. In the African Region, Ethiopia, Guinea, Liberia, Niger, Nigeria and Sierra Leone have national coordinators. In the Eastern Mediterranean Region, steps were taken during 1978 to set up advisory panels of nationals in a number of fields such as malaria, schistosomiasis, veterinary public health, cardiovascular diseases and oral health. Also, there was emphasis in that Region on the better use of national staff and a substantial increase in local disbursements in the form of subsidies for local project staff.

52. Both the Special Programme for Research and Training in Tropical Diseases and the Special Programme of Research, Development and Research Training in Human Reproduction include mechanisms to ensure that research is directed by nationals. Similar mechanisms are seen in the global and regional advisory committees on medical research. Another example of a global operational programme that lays emphasis on the involvement of nationals is the Expanded Programme on Immunization: the first meeting of the Global Advisory Group on the Expanded Programme was held in November, its terms of reference being to advise the Secretariat on programme priorities, promote the exchange of information at all levels, and stimulate support for the programme's goals among political and technical leaders. Coordination and programme support of the mental health programme continued to focus on the formation and strengthening of coordinating groups and on the national infrastructure, including multidisciplinary resource centres located in developing countries.

53. The extent to which governments are taking over projects in which WHO is involved is well illustrated by the UNDP/WHO research project on schistosomiasis control in man-made lakes, responsibility for the operation of which was transferred in December to the Government of Ghana. The project - with its headquarters in Accra and its field station in the resettlement town of Anyaboni - was run under the joint direction of the Ministry of Health and WHO during the period 1971-1978; it amassed a unique collection of data and undertook disease control with drugs for infected persons and chemicals to kill the snails, and through the installation of village water supplies to reduce the daily contact with the lake water. Health education was also a major feature of the project. The bulk of the work was financed by UNDP (African Bureau), which contributed over US$ 2.8 million, and the Government of Ghana provided funds to meet local costs and continued support with manpower, buildings, laboratories and technical inputs. Contributions were also received from Canada, the Netherlands, the United Kingdom, and WHO, as well as major inputs from the Edna McConnell Clark Foundation. The total budget amounted to over US$ 3.8 million. As from the beginning of 1979, the whole of the research work became the responsibility of the Ministry of Health;

[1] WHO Official Records, No. 244, 1978, Annex 7.

[2] The new designation of WHO representatives, in accordance with resolution WHA31.27 (see also para. 34 of this report).

the main financial and logistic support is now being provided by the Government of Ghana, but international cooperation will continue with the Special Programme for Research and Training in Tropical Diseases, supported by contributions from the major donor countries.

More regional centres

54. A policy recently promoted by the Organization is the use of national centres to develop activities for a region. The following are some examples relating to 1978.

55. In the African Region, responsibility for the work of the WHO Immunology Research and Training Centre in Nairobi was handed over to the Kenyan authorities.

56. In the Region of the Americas and the South-East Asia Region, mental health resource centres were set up in Colombia and India respectively to serve the Regions.

57. In the South-East Asia Region, a Regional Demonstration and Training Centre for Oral Health was established in Thailand.

58. In the European Region, in collaboration with UNDP, planning was begun for a Mediterranean Zoonoses Centre in Greece that will also serve the Eastern Mediterranean Region; its function is to provide an information service, train professional and other workers, produce codes of practice for national zoonoses control, develop standardized reagents, and perform other activities connected with zoonoses and foodborne infections.

59. In the Eastern Mediterranean Region, a Regional Research and Training Centre for Vector Biology and Control (Rodents) was set up in Iraq. In the same Region, the library at the Medical Centre in Teheran, Iran, was designated as the WHO Regional Medical Library, with the function of contributing to the transfer of information in the Region about health services and medical care, providing Member countries with wider access to advanced information resources on these subjects.

60. In the Western Pacific Region, an agreement was signed between WHO and the Government of Malaysia establishing a Regional Centre for the Promotion of Environmental Planning and Applied Studies; it will foster collaboration between institutions and personnel of Member States in the Region in the field of environmental planning and human health, promote information exchange, identify and adapt appropriate technology, and act as a regional focal point in this field.

Technical cooperation between WHO and its Member States

61. When considering various proposals for more effective technical cooperation between WHO and its Member States, the Executive Board in January felt that such cooperation should begin at country level. Country health programming was recognized as one of the primary means at the disposal of Member States for developing priority national health programmes and should help to improve the planning, efficiency and effectiveness of health programmes and technical cooperation with and among countries.

62. Outdated donor recipient relationships are giving way to a true partnership between WHO and its Member States, now dedicated to ensuring health for all the world's peoples by the year 2000; this was the central theme of the Executive Board's discussions. In the view of the Board, this new fundamental approach to cooperation in the field of health is bringing new life to the constitutional role and functions of WHO. However, the success of the reorientation of policies and strategies now taking place must inevitably depend upon the degree to which countries collaborate with WHO and actively identify with the goals they have set themselves.

63. An interesting illustration of the way in which technical cooperation between WHO and its Member States is growing is that of the People's Republic of China. October saw the signing of a Memorandum between WHO and the People's Republic of China, providing for broad expansion of technical cooperation. The agreement covers the setting-up of collaborating centres in China in many health fields to perform research as part of a WHO collaborative

programme, the training of Chinese specialists abroad in new techniques, and visits to China under WHO auspices of leading scientists of international renown. China will receive key equipment to help to improve its health and research services. This is the first time that China will undertake technical cooperation with the United Nations system, and the agreement may pave the way to expanded cooperation between China and other specialized agencies. China and WHO have cooperated since 1972 in a joint programme for training health workers from the Third World; under the agreement this training will continue and expand, drawing on support from UNDP.

Technical cooperation among developing countries

64. The Board recognized that the relevance of WHO's programmes to countries' needs could best be ensured by technical cooperation, not only bilaterally between WHO and individual countries but among all Member States, both developing and developed. The concept that permeated the Board's deliberations was that nations should seek the self-reliance that comes from cooperation among equal partners in an increasingly complex world.

65. In August-September, the Organization participated fully in the United Nations Conference on Technical Cooperation among Developing Countries, held in Buenos Aires, Argentina. WHO's involvement received frequent mention in countries' reports on their implementation of technical cooperation programmes. The Special Programme for Research and Training in Tropical Diseases, the essential drugs programme, and the Pan American Zoonoses Centre in Buenos Aires were cited as striking examples of WHO's practical application of the principles of technical cooperation.

66. The WHO delegation to the Conference emphasized the central position of health in the socioeconomic context and the cardinal importance of primary health care. While all delegations readily accepted this new dimension of technical cooperation, some developing countries pressed for new modalities, machinery and methods of financing for it.

67. The implications for the work of the Organization of the "Buenos Aires Plan of Action", as the document that emerged from the Conference is called, are now being studied. The concept of technical cooperation among developing countries will be valid only if those countries are prepared to make a substantial effort to establish firm bases for such cooperation, making effective use of flexible facilitating mechanisms such as WHO.

68. In the Eastern Mediterranean Region, technical cooperation among neighbouring countries continued in the form of border meetings and financial assistance by the richer to the poorer countries. Of particular importance in this connexion is the plan that is being prepared for a coordinated malaria control programme in the Arabian peninsula.

Extrabudgetary funding

69. Massive funds are needed to carry out all the health development activities that are required in order to attain health for all in the next two decades. In 1976 the Health Assembly considered this subject and adopted resolution WHA29.32 on the Executive Board's organizational study on the planning for and impact of extrabudgetary resources on WHO's programmes and policy. In accordance with this resolution, every effort must be made to ensure that the significant amounts of funds that are channelled into health activities in the developing countries through bilateral arrangements are wisely spent on health development programmes consistent with WHO's objectives.

70. The problems posed for the Organization in mobilizing additional funds to carry out its task have become increasingly complex, and in 1978 WHO continued its attempts to attract funds and direct them into appropriate channels. In November, a consultation of representatives from official development agencies, the World Bank and other banks and funds, other agencies within the United Nations system, and a number of developing countries was convened to advise on how best the Organization could secure extrabudgetary support for the growing demands of priority international health programmes, to discuss possible machinery to support the primary health care programme, to promote a dialogue among the aid-giving organizations themselves, with a view to better streamlining of policies and procedures leading to coordinated approaches,

and to present details of WHO programme proposals for donors to consider when planning their budgets.

71. The consultation was characterized by full and frank discussions in which the viewpoint of the developing countries was particularly appreciated. It was acknowledged that opinions expressed in the various governing bodies of the Organization were being fed back into WHO's planning process, that progress was being made towards global agreement on priorities, and that primary health care should be accepted as the umbrella concept under which technical cooperation is to be furnished to developing countries.

72. The participating countries asked WHO to consider the establishment of global mechanisms to facilitate cooperation among contributors themselves and with recipient countries in the health and allied fields and proposed that WHO should act as the focal point of the new mechanisms. It was suggested that a Consultative Group on International Health Funding should be formed around the Director-General, comprising representatives of participating countries, with the aim of attracting bilateral and multilateral funds and ensuring that they are channelled into priority activities in countries. For this purpose, estimates would need to be made of the order of magnitude of the total resources required for health development in the world, including those that need to be transferred between countries and regions. The Director-General accepted the proposals in principle, and they are now being closely studied.

73. As already emphasized, the resources required far exceed WHO's limited budget, which needs to be complemented by contributions from other agencies; by virtue of such contributions over the years the Organization has been able to increase the effectiveness of its activities to a remarkable extent. The following is merely a selection of instances of extrabudgetary funding during 1978; many more could be quoted.

74. In response to an appeal by the Director-General of WHO for continued support for the smallpox eradication programme, the Netherlands Government in May announced a contribution of US$ 1.84 million to cover the estimated cost of the continuing search and surveillance programme until the certification of worldwide smallpox eradication. International assistance for the smallpox eradication programme, including that received by WHO and support through bilateral channels, has been provided by a total of 44 countries since 1967; it includes US$ 26 million from the United States of America, US$ 16 million from Sweden, and US$ 13 million from the Union of Soviet Socialist Republics, and more than US$ 500 000 each from Canada, Denmark, India, Iran, Japan, Norway and the United Kingdom.

75. Vectorborne diseases are endemic in many rural and some urban areas of Burma, resulting in decreased labour productivity in basic industries such as agriculture, forestry and mining; control of these diseases has high priority in Burma's health programme. In September CIDA agreed to contribute US$ 5.6 million to a five-year programme administered by WHO and the Government of Burma to combat vectorborne diseases in Burma. The programme aims to reduce the incidence of malaria, dengue haemorrhagic fever, filariasis and Japanese encephalitis by 25%. WHO is contributing US$ 1.4 million and UNICEF US$ 1.9 million to the programme, and Burma will invest a further US$ 1.5 million in local costs. The Canadian grant will purchase insecticides, prophylactic drugs, spraying equipment, laboratory equipment and vehicles.

76. SIDA provided US$ 17.5 million, to be spread over five years, for malaria control in India (the Plasmodium falciparum containment programme).

77. Following a major increase in the incidence of malaria in Turkey, the WHO Regional Director for Europe, in consultation with the Government of Turkey, appealed directly to other countries concerned and to potential donors to make international cooperation more effective in the fight against malaria. WHO sent an intercountry team of medical and engineering specialists to Turkey and strengthened its services so as to obtain commodities, including insecticides, drugs and vehicles, required for the Turkish antimalaria programme. UNICEF and a number of countries pledged contributions in this respect, including Bulgaria, the Federal Republic of Germany, Greece, Luxembourg, Norway, Switzerland and the United Kingdom. As a result, all the equipment and supplies needed for operations in 1978 were obtained and field activities were implemented according to schedule. A total of US$ 3.8 million was raised for the emergency, and a UNDP-financed intercountry project was created, combining the efforts of

Bulgaria, Greece, Turkey and Yugoslavia to control malaria in South-East Europe and prevent its spread to the rest of the continent.

78. In the Eastern Mediterranean Region, WHO provided support to the Government of Sudan in obtaining a loan of US$ 6 million from the African Development Bank for the development of health services. Collaboration was initiated with the Arab Fund for Social and Economic Development for assistance in connexion with integrated rural development in Democratic Yemen, Mauritania, Somalia, Sudan and Yemen, and position papers were prepared on health, environmental sanitation and water supply in the rural areas. An Agreement and a Memorandum of Understanding were signed with the Islamic Development Bank under which the Regional Office is the focal point for health and health-related projects supported by the Bank. The Agreement, similar to that between WHO and the African Development Bank, was approved by the Health Assembly in May. It provides for financial input by the Bank for health development in countries that are members of both the Bank and WHO - there are, at present, 42 such countries - with WHO as the executing agency.

79. In August, the Japan Shipbuilding Industry Foundation made a voluntary contribution of US$ 3.3 million for WHO regional activities in the Western Pacific and for programmes in leprosy control, smallpox eradication, the prevention of blindness, and tropical disease research. This contribution brought to more than US$ 6.3 million the amount contributed by the Foundation to WHO in three years.

International Conference on Primary Health Care

80. An outstanding event of the year was the International Conference on Primary Health Care, jointly organized and sponsored by WHO and UNICEF, held from 6 to 12 September in Alma-Ata, USSR, at the invitation of the Government of the Union of Soviet Socialist Republics. The Conference was attended by high-level delegations from 134 governments and by representatives of 67 organizations and specialized agencies of the United Nations system and intergovernmental organizations, including UNDP, UNEP, UNFPA, UNIDO, ILO, FAO, UNESCO, and the World Bank, and nongovernmental organizations in official relations with WHO and UNICEF. They studied a joint report by the Director-General of WHO and the Executive Director of UNICEF, six regional background reports prepared by the WHO regional directors, and a wide variety of other official Conference documentation. The programme of work proceeded smoothly, and the Conference adopted the Declaration of Alma-Ata and a series of 22 specific recommendations contained in its final report.[1]

81. In 1977 the Health Assembly had taken what can only be described as a momentous decision, namely that the social target of governments and of WHO should be "health for all by the year 2000", that is, the attainment by all the citizens of the world by that date of a level of health that will permit them to lead a socially and economically productive life. The Conference asserted that primary health care is the key to health for all. The Declaration of Alma-Ata states the fundamental principles upon which the health policies of all countries should be based, emphasizing health as a fundamental right and its attainment as a worldwide social goal. The Conference may therefore be considered as a turning-point in the development of concepts relating to primary health care. The issues involved were clarified, and political agreement and technical consensus were reached.

82. The Conference called for "urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order". Primary health care was defined as essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation, and at a cost that the community and the country can afford. Primary health care forms an integral part both of the country's health system, of which it is the nucleus, and of the overall social and economic development of the community.

[1] Alma-Ata 1978: Primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Geneva, World Health Organization, 1978.

83. The Conference brought about a fundamental change in policy - a move away from single-disease programmes to an approach closely linked to overall development and directed towards solving problems as perceived by the people themselves. The results of the Conference will be used nationally, subregionally and regionally in formulating strategies and developing plans of action for primary health care as the key to attaining an acceptable level of health for all.

84. Following on the Conference, in response to its challenge concerning national and international action, the Executive Board issued a call to develop strategies. It drew up a preliminary document which is being transmitted by the Board to the Health Assembly in May 1979 with the title "Formulating strategies for health for all by the year 2000 - guiding principles and essential issues".[1] The document stresses that strategies must be built up first at the national, then at the regional and finally at the global level.

85. There are signs that countries are responding to Alma-Ata, as reflected in the discussions and decisions of the regional committees and subsequent action in countries. For instance primary health care was adopted by all countries in the African Region as the main approach in the health delivery system, and most of the countries of the Region are implementing it, giving particular emphasis to maternal and child health, nutrition, immunization and basic sanitary measures.

86. The Regional Committee for the Americas expressed the conviction in October that the existing inequalities in people's health status are unacceptable and a cause of concern to all countries. It urged governments that have not yet completed plans for extending health services to all their people to give priority to this task. It also recommended that governments expedite the implementation of their plans for health coverage of the population and that they develop primary health care as part of overall health care, with due attention to the various levels of care, referral systems, and supervision.

87. The Regional Committee for South-East Asia noted that the primary health care approach had been accepted in all countries of the Region, and programmes were in progress in most countries, using community health workers chosen and guided by the community. Stress was laid on the need to implement health care programmes in conformity with the life pattern of the community. In December, a meeting on primary health care in the Region brought together participants representing health, planning, finance and health-related sectors of government and United Nations agencies and other organizations interested in primary health care. As a direct follow-up of the Alma-Ata Conference, the meeting discussed ways of formulating and implementing national and regional primary health care programmes, drew up an outline of the medium-term programme for primary health care for the Region for 1978-1983 and discussed appropriate technology for health in the context of primary health care.

88. The Regional Committee for Europe stressed the importance of the Alma-Ata Conference and the resulting documents and considered that, although much of the discussion had been concerned with developing countries, the concepts involved were equally valid for the European Region. The Regional Committee felt that, since the concept of primary health care as developed at Alma-Ata encompassed a wide range of activities, careful coordination was essential. It urged Member States to take account of the Conference recommendations in their national health programmes and plans and requested the Regional Director to integrate the recommendations into the European regional programme. To that end, an assessment of the situation in the European Region was begun and proposals for new strategies are in preparation.

89. In the Eastern Mediterranean Region, a regional advisory panel on primary health care was formed during 1978. It comprises senior public health administrators and educators - including physicians, nurses and sanitary engineers - from selected countries in the Region, who have been involved in primary health care programmes in their own countries. The main function of the panel, which held its first meeting in December, is to advise the Regional Director on the further development of primary health care in the Region.

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[1] See Annex 2.

90. As part of the development of the primary health care concept in the Western Pacific Region, intercountry workshops on the subject were held in Malaysia in November and in the Republic of Korea in December. Collaboration in this field was strengthened with the Ministry of Health in Malaysia, the Institute of Health Sciences in the Philippines, and with the Korea Health Development Institute in the Republic of Korea. Five countries in the Region were represented on a three-week study tour in August in the People's Republic of China to observe the training and utilization of barefoot doctors in community health.

91. Within countries, the consequences of the decisions taken at the Conference are likely to be seen in the development of appropriate strategies, including the reform of entire health systems, not merely those parts concerned with primary health care. The reaction of governments is awaited with interest. Will countries - the developed no less than the developing - reorganize their health systems, change budgeting procedures, train the necessary personnel, redistribute resources for health to rural areas, and integrate health into development? The altered emphasis on the underserved majority implies the transfer of a greater share of health resources from urban to rural areas - a policy that may conflict with the interests of the urban elite, usually the best organized and most vociferous element of the population.

Development of comprehensive health services

92. Appropriate technology for health. A WHO programme whose aim is to introduce, adapt and develop health technologies that are appropriate to needs and resources, especially of the developing countries, was approved by the Health Assembly in May. Designed to encourage self-reliance in solving health problems, the programme of appropriate technology for health will also help the developing countries to reduce their dependence on imported or inappropriate technologies. The programme is part of WHO's efforts to build up primary health care in both developing and developed countries. The Organization sees its role in this field as coordination of a collaborative effort by interested countries around the world.

93. Much of the technology produced and used in developed countries, based on capital-intensive techniques and highly trained personnel, is expensive and often ill-adapted to requirements even in its original setting; it is still less suited to the developing countries. "Technology" is taken to mean an association of techniques and equipment which, together with the people using them, can contribute significantly to solving a health problem. "Appropriate" means that, besides being scientifically sound, the technology is also acceptable to those who apply it and those for whom it is used.

94. In the same way as primary health care, appropriate technology for health is an activity that cuts across all of WHO's programmes, and many components of different programmes could be classified as appropriate technology for health - for instance, the development of prophylactic vaccines against tropical diseases, devising improved methods for detecting cases of tropical diseases, developing socially acceptable fertility regulating methods, promoting the use of auxiliaries instead of doctors and nurses, working out simple methods of mental health care (e.g., trials of "one-drug therapy" for epilepsy and for some widespread mental disorders), developing health laboratory technology and simple health care facilities suitable for developing countries, research on inexpensive housing that does not attract or harbour disease vectors, and research on the use of low-cost water-piping such as lengths of bamboo. Country health programming can also be considered as appropriate technology for health.

95. Many other health activities undertaken during 1978 were directed towards the development of appropriate technology; the following are a few examples taken at random. A basic radiological unit that is reliable, inexpensive and easy to operate was under consideration in the Eastern Mediterranean Region as a possible means of improving the quality and extending the coverage of primary health care in peripheral areas. The problem of storage of vaccines in hot climates was being tackled by the production locally of cold-box prototypes in India, Indonesia, Nepal and Thailand. Field demonstrations of the effectiveness of various agents for the prevention of oral diseases were in progress in Thailand and French Polynesia. In the Region of the Americas, the possibility was being investigated of using salt as a vehicle for fluoride in the prevention of dental caries. Sugar was being fortified with vitamin A in Central American countries, and the development of sugar fortification with iron salts was being pursued. The use of oral rehydration to combat diarrhoea was being extended in various

parts of the world, and techniques were being developed for the production of the necessary electrolytes in developing countries.

96. A time-honoured form of appropriate technology for health is the widespread use of medicinal plants in the health care systems of many countries, and especially developing countries. The Health Assembly debated this subject in May and, in accordance with its decision, the Organization in 1978 took the first steps in the task of compiling an inventory of such plants, with standardized botanical nomenclature for those most widely used. The therapeutic classification of the plants will be related to that of drugs, and available scientific data relating to efficacy in the treatment of specific conditions and diseases will be reviewed and summarized. WHO is designating regional research and training centres for the study of medicinal plants and will coordinate the efforts of Member States in developing and applying scientific criteria and methods for testing safety and efficacy, in establishing international standards and specifications for identity, purity and strength, and in developing methods for safe and effective use. As part of these activities, experts met in Geneva in October to study the best ways of drawing up a list of the most widely used medicinal plants. They agreed that several crude drugs can be extracted from medicinal plants without highly sophisticated equipment and may be effectively used in treating certain diarrhoeal disorders, benign hypertension and some forms of diabetes mellitus. They also examined methods of drawing up a schedule of the nomenclature and specifications of medicinal plants.

97. An important special group of medicinal plants is that used for regulating fertility. As part of the Special Programme of Research, Development and Research Training in Human Reproduction, WHO designated six centres to carry out research aimed at obtaining new and effective fertility regulating agents from plants. Information already available, covering about 3000 plants, was computerized. The data were found to vary considerably in scientific reliability, and a computerized points system of weighting was devised to provide a priority rank-ordered list of plants from which the most appropriate ones could be selected for experimental investigation by the centres. No chemical work will be initiated on a plant until its biological activity is confirmed independently by two groups. The work in the centres will be complemented by specific ethnobotanical and/or anthropological studies in certain areas where appropriate.

98. Nutrition. Adequate nutrition is a fundamental requirement for sound health. In many countries urgent action is needed to raise nutritional standards as one of the first moves in improving the health status of the population. The Executive Board in January considered the role of the health sector in the development of national and international food and nutrition policies and plans, and endorsed a proposal to set up a coordinated international programme of action-oriented research and training in nutrition, aimed at developing approaches and methodologies for dealing with malnutrition at the community level under different ecological and sociocultural conditions.

99. When debating this proposal in May, the Health Assembly acknowledged that malnutrition is one of the major obstacles to attaining the goal of health for all. Several delegates supported the proposed coordinated multisectoral approach for nutrition policies and programmes. Within the specific concerns of the health sector, particular attention was given to the decline in breast-feeding which continued in many countries, although an arrest or reversal of this trend had been noted in a few, and to the health and nutrition problems associated with early or inappropriate weaning. Member States were therefore asked to give the highest priority to the prevention of malnutrition in pregnant and lactating women, infants, and young children by promoting breast-feeding by means of health education and social legislative supporting measures, and by ensuring timely and appropriate weaning with maximum use of locally available and acceptable foods.

100. In accordance with the Health Assembly's request, the Organization began in 1978 to develop with Member States a research and development programme in nutrition, primarily oriented to the needs of developing countries, and initially aimed at the prevention of malnutrition in mothers and young children by the efficient utilization of local resources. WHO is cooperating with national institutions to strengthen their capacity to combat malnutrition, and is collaborating with multilateral, bilateral, intergovernmental and nongovernmental

organizations and agencies in programmes of technical cooperation with countries for the development and implementation of national food and nutrition policies, plans and programmes. In brief, the Organization is trying to stimulate the mobilization of scientific and financial resources in support of a global effort to eliminate malnutrition.

101. Human reproduction. In 1978 the Special Programme of Research, Development, and Research Training in Human Reproduction completed its seventh year. In March, a group of eminent scientists, research administrators and health service administrators carried out an extensive review of this activity; they indicated ways in which its management should be adjusted or improved, but commended the progress achieved in a relatively short period of time. They concluded that there was still a high-priority need for programmes in this area, and they felt that the Special Programme should continue to be strongly goal-oriented towards achieving its current objectives and should not expand into other aspects of human reproduction.

102. During 1978 the Special Programme increased its research on the safety of current methods of fertility control in developing countries, including studies, never before conducted in those countries, on long-term sequelae. There was an increase in health service research on family planning, and institution-strengthening activities were intensified in developing countries. In addition, work was continued on the effectiveness and acceptability of existing family planning methods, the development of new methods, the treatment of infertility, and the health rationale for family planning.[1]

103. In May, the Health Assembly endorsed the objectives of the Special Programme and urged Member States to participate as fully as possible in this work. The Director-General was asked to intensify health service research so as to facilitate the integration of fertility regulation services within countries' primary health care systems and to secure the cooperation of the pharmaceutical industry in the work of the Special Programme.

104. Mental health. The components of health, as defined in WHO's Constitution, include mental and social wellbeing, and the non-physical aspects of health have always received due attention in the Organization's activities. In January the Executive Board examined and approved the strategy, objectives and content of the medium-term programme for mental health, and in May the programme was transmitted to the Health Assembly, which also approved it. For the first time in the history of the Organization, mental health is recognized as a global concern: the programme stresses the public health and social aspects of mental health rather than linking it only to mental diseases and to psychiatry. The objectives of the programme are threefold: to prevent or reduce psychiatric, neurological and psychosocial problems, including those related to alcoholism and drug dependence and the psychosocial components of physical disease; to increase the effectiveness of the general health services through appropriate utilization of mental health skills and knowledge, as exemplified by work on the psychosocial development of the child; and to develop strategies for intervention based on an increased awareness of the mental health aspects of social action and change (for instance, the psychosocial factors that may determine the success or failure of major public health initiatives and programmes).

105. These objectives were formulated after consultations with developing and developed countries, through workshops and task force meetings involving scientists and workers in mental health and other fields. Data on mental health problems were obtained through special studies and country visits. Other international and regional organizations were consulted. Coordinating mechanisms were set up in countries, at regional level and globally to ensure that the programme remains multidisciplinary, multisectoral, and constantly responsive to the changing needs of countries.

106. The programme is based on three premises. First, a reorientation of thinking about mental health and about the role of the mental health professions is essential before any action can be successful. Secondly, mental health programmes must be carried out with close

[1] For full details of these activities, see Special programme of research, development, and research training in human reproduction, seventh annual report, November 1978 (WHO document HRP/78.3).

collaboration among the different social sectors such as education, social welfare, labour, and health, rather than by the mental health professions alone. Thirdly, cooperation between countries in the resolution of their mental health problems is necessary if progress is to be achieved.

107. The programme is designed to facilitate the application of these ideas. It involves a wide range of disciplines: its concerns range from mental and neurological disorders, alcohol and drug dependence to problems such as uprooting, psychosocial sequelae of changes in family structure, and the promotion of a healthy psychosocial development. It was devised in cooperation with countries, and its implementation depends on joint work with many governments, institutions and experts in nearly all countries of the world. The coordinating mechanisms mentioned above play an important role in this process. The new concept of multidisciplinary resource centres for mental health has been developed, and several such centres are being put into operation to facilitate programme development and coordination at the country, regional and global levels.

108. Essential drugs. A prerequisite of the provision of primary health care is an adequate supply of reasonably-priced medicaments for treating common conditions. In January, the Executive Board examined and commended the report, just issued, of a WHO Expert Committee containing a model list of 200 essential drugs.[1] The report, while generally supported in public health circles, was strongly opposed by medical and pharmaceutical groups in some countries. It adopted a new approach by focusing on those drugs and vaccines that are indispensable in catering for the health needs of the majority of the population. The main principle guiding the Expert Committee was to include only those drugs for which adequate scientific data on benefits and risks are available. The model list was considered a basis for countries to identify their own priorities and make their own selection, and not as a drug list of uniform, general applicability throughout the world; several Board members stressed the need for a flexible approach in this regard.

109. Calling for an action programme of technical cooperation on essential drugs, the Board emphasized the importance of dialogue and collaboration with private or state-owned pharmaceutical companies, in particular to secure essential drugs under special conditions (e.g., very low prices and special packaging and labelling) for exclusive use in the public sector of health services of the least developed countries. As regards the long-term goal of self-reliance in drug production by developing countries, the Board welcomed the Joint Inter-Secretariat Task Force formed by WHO, UNIDO and UNCTAD in an effort to overcome practical problems involved in the transfer of technology.

110. In the light of the Board's remarks, efforts were continued to identify drugs and vaccines indispensable for primary health care and disease control in the vast majority of the population. WHO collaborated with Member States in formulating drug policies and programmes aimed at ensuring access of the whole population to essential drugs at a cost the country can afford, and fostered technical cooperation among developing countries for the formulation of drug programmes, including the local production of essential drugs and vaccines. In addition, the Organization attempted to stimulate bilateral and multilateral cooperation to provide support for such programmes, and provided assistance in the development of systems of quality control.

111. The Technical Discussions held during the Health Assembly in May were on the subject of general policies and practices in regard to medicinal products. The Technical Discussions provided an opportunity for Member States to review the various aspects of national and international drug policies as they relate to health priorities and to exchange views and experiences at the national, regional and global levels, especially on technical cooperation and the role of WHO. The shortages of drugs in many developing countries were recognized to be related to inadequate distribution and to the high cost of such products. It was recommended that these countries should not lose sight of their own responsibilities and should commit themselves immediately to eliminating these two main causes of drug shortages. The participants concluded that countries should take a political decision at the highest level to ensure health for every-

[1] WHO Technical Report Series, No. 615, 1977.

one and therefore bring medicinal products to all who need them. Immediate action is required: there is no justification for waiting until other conditions have been fulfilled, such as the training of additional health workers or improvement in economic development.

112. The Technical Discussions constituted the first world forum at which Member countries and the pharmaceutical industry could debate basic problems in world pharmaceutical supply systems. The participants concluded that the Technical Discussions were a starting-point for a series of activities that would lead to an early solution of the problem of providing the developing countries with all the essential drugs they need. WHO's central role and responsibilities in this endeavour were acknowledged to be fundamental and indispensable if progress and success were to be achieved.

113. The Executive Board's proposals and the content of the Technical Discussions formed the basis of a long debate by the Health Assembly in May, when many delegates from both developing and developed countries voiced their concern at the present situation of drug production and distribution to most parts of the world. In accordance with the Assembly's decision, the Organization in 1978 began developing a comprehensive action programme on essential drugs aimed at strengthening, through technical cooperation among countries, the national capabilities of developing countries in the selection, supply, distribution and proper use of essential drugs and, whenever feasible, the quality control and local production of such drugs. The immediate aim of the programme is to make essential drugs available, on favourable terms, to the least developed among developing countries.

114. The dialogue with the pharmaceutical industry called for by the Assembly produced results in that some major drug manufacturers pledged their participation. A number of major drug firms made an offer to WHO to place certain highly useful drugs at the disposal of the world's most underprivileged countries under special conditions. The ten products concerned have been used for many years against certain communicable diseases including leprosy, malaria, Chagas' disease and other tropical parasitic diseases. The manufacturers' proposals stipulated that all the special conditions and prices should be discussed country by country, with WHO acting as intermediary and coordinator. Discussions on the subject have since been initiated.

115. There was considerable activity in the regions in the field of essential drugs, as shown by the following examples. In the Region of the Americas, the subject of the Technical Discussions during the Regional Committee was "The impact of drugs on health costs: national and international problems". Contact was established with the Federation of Latin American Pharmaceutical Industries with a view to identifying public health problems that require collaboration with the industry for their solution. With the aid of CIDA, steps were taken towards establishing a regional drug-testing laboratory in Jamaica. The above-mentioned report of the WHO Expert Committee on the Selection of Essential Drugs was discussed and endorsed at two WHO regional meetings in March, in Colombo and Manila, and as a result a start was made on developing regional programmes on drug policy and management. In the South-East Asia Region, work on adapting the WHO list of essential drugs to national needs was started in Bangladesh, Burma, India, Indonesia, Nepal and Sri Lanka, and in some of these countries particular attention was paid to drug manufacturing facilities. In the Western Pacific Region, preliminary surveys of the drug policy and management situation were carried out in Fiji, Papua New Guinea, Samoa, Solomon Islands and Tonga, and at a meeting in December a regional list of drugs was adopted and it was proposed that a regional pharmaceutical service be established to deal with procurement, quality control, storage and distribution.

Disease prevention and control

116. Malaria control programme. In view of the continuing resurgence of malaria in some countries of South-East Asia and in Turkey, the slow or virtually non-existent progress in malaria control in a number of countries in Asia and in Latin America, and the unchanged endemicity level of malaria in Africa south of the Sahara, the Executive Board, meeting in January, again reviewed malaria control strategy and concluded that no global eradication approach was currently possible because of administrative, operational and technical problems, such as vector resistance to insecticides and Plasmodium falciparum resistance to certain drugs. Thus, with the tools at present available, the transmission of malaria cannot be

interrupted in many parts of Africa. It was emphasized that, although WHO is already attempting to promote the solution of some of these problems, political decisions at the national level are the crucial factor in any malaria control programme.

117. In May, after a long debate on the critical situation in malaria, the Health Assembly declared that the dramatic recrudescence could not be stopped unless firm national commitments are made to combat the disease and adequate resources are devoted to antimalaria activities, both nationally and internationally. In many parts of the world, malaria is jeopardizing not only the health of the population but also overall socioeconomic development. The building of barrages, dams, and artificial lakes has also contributed to the spread of the disease. However, the present trend of deterioration could be reversed, given the determination and political will of Member countries to take action, by the judicious selection and utilization of malaria control methods that are already available.

118. The Assembly urged Member States to reorient their antimalaria programmes - with the final objective of eradication where possible - as integral parts of their national health programmes and to increase their fiscal, administrative and technical commitments against malaria within their national development plans. The long-term goal of the Organization's antimalaria programme remains eradication, but the Assembly approved a strategy with the short-term objectives of reducing the levels of transmission in epidemic areas, reducing the societal and economic effects of the disease, reducing malaria fatality rates, and halting the spread of the disease to areas that have been freed from malaria. The medium-term objectives of the programme are to reduce endemicity to levels not hampering socioeconomic development, and to reduce malaria-specific mortality to negligible levels. According to the strategy, the utmost flexibility should be exercised in the planning of any type of malaria control activities, depending on local circumstances and resources. There should be a government commitment to support antimalaria activities for the necessary time period. The type of programme selected must be feasible given the local situation, must have the full support of whatever type of health service exists in the country, and must have the participation of the community. Each country must decide what strategy it can implement, but it is obviously desirable that neighbouring countries should agree on common targets and coordinate their activities.

119. Diarrhoeal diseases. Diarrhoeal diseases constitute a serious socioeconomic and public health problem in many countries and contribute to the high morbidity and mortality rates, particularly in children. Progress has been made in developing simplified and effective methods for diagnosis and treatment by oral rehydration. The Health Assembly in May urged Member States to identify these diseases as a major priority area for action and to apply known effective measures for their management and control in the context of primary health care.

120. With a view to launching a major attack on these diseases, the Organization had already embarked on action at the country, regional and global levels - promoting activities and research on etiology, epidemiology, pathophysiology, management of cases, immunology and vaccine development, promotion of breast-feeding and other aspects of child care, nutrition and environmental health. Both UNICEF and the Government of the United Kingdom had supported these activities, and the Health Assembly gratefully acknowledged this collaboration.

121. In accordance with the Assembly's instructions, WHO in 1978 began intensifying the involvement of Member States in developing a plan of action for an expanded programme on diarrhoeal disease control. Technical cooperation is now in progress with and among Member States in connexion with this programme, including the training of health workers at different levels. High priority is being given to research for the development of appropriate methods of treatment, prevention and control in areas with various kinds of health service facilities.

122. The long-term objective of the programme is to eliminate diarrhoeal diseases as a public health problem by improving water supply and sanitation, promoting health education, and undertaking other general community hygiene measures. The immediate and medium-term objectives are to generalize the use of oral rehydration therapy, which can virtually eliminate mortality from acute diarrhoeal diseases, to combine that therapy with proper feeding practices to minimize the ill effects (especially malnutrition) associated with these diseases in

children, and - with a view to reducing their incidence - to encourage suitable child care practices, improve water supply and sanitation, promote health education, and develop other measures to interrupt transmission and prevent infection.

123. Country programmes for the control of diarrhoeal diseases should take their place as part of national health programmes and primary health care activities. In the Eastern Mediterranean Region, a regional meeting in June formulated a regional plan for coordinated action in the control of diarrhoeal diseases. The WHO regional advisory committees on medical research in Africa, South-East Asia, the Eastern Mediterranean and the Western Pacific gave priority to research on these diseases, and programmes of research on topics of regional and local importance are being formulated. The advisory committees are using diarrhoeal disease control as a model for building up a global research programme, starting at the country level and working up through the regional to the global level.[1]

124. Smallpox eradication. No cases of endemic smallpox were detected during 1978, the last such outbreak having occurred in Merka City, Somalia, in October 1977. Active surveillance programmes aimed at detecting smallpox cases continued in the Horn of Africa (Djibouti, Ethiopia, Kenya, and Somalia), in neighbouring countries (Democratic Yemen and Yemen) and in other countries preparing for certification of freedom from smallpox. During 1978, 4577 specimens from 36 countries were tested for variola virus by WHO collaborating centres; none contained variola virus.

125. A smallpox outbreak associated with a laboratory retaining variola virus occurred in Birmingham, United Kingdom, in August and September. Two cases occurred and one patient died. Immediate and complete surveillance-containment measures were initiated by the health authorities, resulting in the immediate extinction of the outbreak after only one case of secondary spread.

126. In 1978 six countries were certified free from smallpox by international commissions: Malawi, Mozambique, United Republic of Tanzania, and Zambia (all in March), Uganda (October) and Sudan (November). Certification of worldwide eradication is scheduled for the end of 1979, two years after the onset of the last case in an endemic area.

127. The Director-General formed the Global Commission for the Certification of Smallpox Eradication on the recommendation of the Executive Board. The Commission was charged with monitoring the activities leading to worldwide certification of freedom from smallpox and informing the Director-General whether the criteria for global eradication had been met. At its first meeting, in December, it reviewed documentation, surveys and field visits of WHO staff and Commission members, completed in 1978. The Commission certified a total of 64 countries as smallpox-free, including those mentioned above, leaving 15 countries to be certified in 1979.

128. In January 1978 there were 18 laboratories in the world retaining variola virus. Major efforts were made to implement resolution WHA31.34 requesting all laboratories except WHO collaborating centres to destroy remaining stocks of variola virus or transfer them to a collaborating centre. By December 1978 there were some 10 laboratories retaining variola virus, four of them WHO collaborating centres. During the year four laboratories were visited by members of the Global Commission to ensure compliance with the WHO recommendation and to promote safety in these laboratories. It is intended to reduce the number of such laboratories to not more than four by 1980.

129. During 1978, 21 958 000 doses of smallpox vaccine were contributed to WHO from four countries. The establishment of a vaccine storage facility was started in New Delhi for the permanent storage of smallpox vaccine after worldwide certification is confirmed. With WHO headquarters, this makes two sites for a vaccine reserve; a third site is under consideration.

130. Three countries ceased routine smallpox vaccination during 1978. There are now 45 such countries in the world.

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[1] See also para. 163.

131. Six cases of human monkeypox were detected in Zaire during 1978, bringing to 35 the total number of cases reported to date. No man-to-man transmission occurred. This information, coupled with previous observations, further indicates that the disease is not highly transmissible between humans and is not a menace to the global programme. An informal consultation on monkeypox and whitepox viruses was held in Geneva in November 1978. The participants recommended further elucidation of the origins of whitepox virus and its characterization. Surveillance for poxvirus disease in humans in Zaire was also recommended, as was the setting-up of a scientific mission to attempt to discover the animal reservoir of human monkeypox. A surveillance programme for poxvirus disease continues in Zaire and a special scientific mission is programmed for 1979.

132. Expanded Programme on Immunization. In May, the Health Assembly, having studied a progress report on the Expanded Programme on Immunization, asked the Director-General to give high priority to the implementation of the Programme so as to achieve the goal of immunizing every child in the world against diphtheria, pertussis, tetanus, measles, poliomyelitis and tuberculosis by 1990. The Assembly noted the accomplishments of the Programme, especially in strengthening national capacities, improving the cold chain technology, and improving vaccines and vaccine delivery systems. The establishment of a global advisory group for the Programme was welcomed and potential donors, including Member States, were urged to support programme implementation in countries through medium- and long-term commitments.

133. Fifteen governments in the Eastern Mediterranean Region were actively involved with WHO in the Expanded Programme on Immunization. National programmes were under way in nine countries, and seven countries were cooperating with WHO in a UNDP-supported interregional project for vaccine production and quality control. A national course in the management of the Expanded Programme arranged in Pakistan in September used national epidemiological and immunization performance data as material for the training exercises. Similar training courses were held in September in the South-East Asia and Western Pacific Regions (India and Fiji, respectively).

134. Tropical disease research. The Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases, holding its first meeting in Geneva in November, approved a maximum budget for 1979 of US$ 25.5 million, of which US$ 22 million had already been made available or pledged. The Joint Coordinating Board, now the overall administrative body for the Special Programme, comprises 27 governments and organizations and representatives of the three co-sponsors - UNDP, the World Bank and WHO. The Special Programme was launched in 1976 to develop effective control measures against malaria, schistosomiasis, filariasis (including onchocerciasis), African and American trypanosomiasis, leishmaniasis and leprosy.

135. The Joint Coordinating Board was reminded that in the past, when industrialized countries had mounted campaigns aimed at worldwide health problems, it had been they who often reaped the greatest rewards. But all countries would benefit from the Special Programme, although the technology evolved would have a greater and more immediate impact on the health situation in developing countries. The Programme operates in such a way as to involve these countries in solving their own disease problems. At the same time, the management system that has been developed ensures that the scientific community as a whole participates fully in setting the broad scientific priorities and engaging in goal-oriented research leading to the development of new drugs, diagnostic tests, vaccines, pesticides and other tools.

136. 1978 saw a rapid scientific and technical growth of the Special Programme, which is wholly relevant to some of the most acute health problems of the developing world. An important component is the strengthening of research institutions in tropical countries. The Programme is concerned both with training leaders in research and with supporting workers in the laboratory, the clinic and the field. Manpower development and the strengthening of research institutions are intimately related to the search for new tools, and the Programme seeks to coordinate and integrate the actual research and development with the institution-strengthening activities, increasing the involvement of scientists from countries where the diseases are endemic and ensuring the provision of career structures for scientists in those countries.

137. Prevention of blindness. The WHO programme for the prevention of blindness became fully operational as from the beginning of 1978. In February, an advisory meeting was held on this subject. The basic recommendation to WHO was that the right to see must be recognized as an important component of public health activity requiring massive support. Elimination of blindness due to trachoma, onchocerciasis, and xerophthalmia is possible, and the cost-effectiveness of such action is high. The relief of easily curable blindness caused by cataract also offers independence to the individual and substantially increased productivity. Blindness prevention does not always necessitate the intervention of medical practitioners: it is becoming increasingly evident that action directed towards various interrelated factors such as nutrition, economic and social conditions, environment, education, and group behaviour is essential in order to prevent blindness. The participation of the community - collectively and as individuals - is a prerequisite for any blindness control programme.

138. During 1978 a global advisory group was established, and initial steps were taken to designate a network of WHO collaborating centres in all regions. A task force defined principles for strategic planning, and a meeting on technical and operational approaches in October prepared guidelines for such programmes. The basic approach is the promotion of regional and country programmes within the context of primary health care. The Organization's role is that of a catalyst facilitating the development of national programmes and manpower at various professional levels. Coordination with nongovernmental organizations, and in particular the International Agency for the Prevention of Blindness, proceeded very satisfactorily in 1978, with emphasis on public information and mobilization of resources.

139. Activities developed in the regions, reflecting different conditions and priorities. Focal groups were designated in all regional offices and working groups established in Africa, the Americas, South-East Asia and the Western Pacific. In the Eastern Mediterranean Region, a committee to study promotive measures for the prevention of blindness met in Teheran, Iran, in March. As a follow-up of this meeting, a technical committee, consisting of ophthalmologists from seven countries, met in June to formulate a plan of operation.

140. Hypertension. World Health Day can be regarded as one mechanism for creating awareness of health matters. World Health Day 1978 had as its theme "Down with hypertension", in recognition of the global significance of this health problem. In collaboration with the International Society and Federation of Cardiology, an extensive information programme was launched which was successfully implemented through the WHO regional offices and the governments of many Member States, as well as through national cardiological societies. An information kit composed of articles and press releases was compiled and sent out and was reproduced widely in all of the regions. Two one-minute films and a series of radio interviews were also prepared and distributed. A special seminar for science writers, during which they had the opportunity to ask questions of members of the WHO Expert Committee on Arterial Hypertension, resulted in a number of feature articles and syndicated items in the press.

141. Industrialized as well as developing countries participated actively in World Health Day. Judging from the reaction in individual countries, it seems likely that this activity was not a one-time campaign, but that in many countries it launched a long-term programme in control of hypertension at the community level. The most striking characteristic of the event was the cross-fertilization of ideas and experiences. The public in Central America became acquainted with health problems and solutions in Asia and Africa, for example. The press in Latin America gave prominence to the question of high blood pressure and the social and anthropological characteristics associated with it.

142. Although no precise measure can be made of what practical effects World Health Day had in individual countries, there is no doubt that it spurred national programmes to greater efforts in many cases and helped to initiate them in places where there had been none before. Above all, the community-based approach, with its emphasis on how individuals can change their own life-style in order to affect their health, seems to be widely understood and is beginning to be applied.

143. Antismoking measures. The level of health of a population cannot be raised solely by efforts directed from outside that population: active involvement on the part of the community and the individual is essential. Individuals must be motivated to improve and maintain their own health if they are to benefit to the full from health activities carried out by others on their behalf. This requirement is especially relevant to the control of smoking.

144. With little being done to combat the health hazards of smoking despite increasing and indisputable scientific evidence of the threat it poses, the Health Assembly in May endorsed a four-part programme urging Member States to strengthen health education programmes about tobacco smoking; to adopt comprehensive measures, including higher taxes on cigarettes and restrictions on cigarette advertising and promotion; to protect the rights of nonsmokers by limiting the places where smoking is permitted; and to seek economically sound alternatives to tobacco growing and processing.

145. In the light of the Assembly's deliberations, a WHO Expert Committee on Smoking Control was convened in Geneva in October. The following are some of its recommendations: that tobacco growing and manufacturing should not be promoted in developing countries, that the export of tobacco and tobacco products from developed countries should be prohibited, that tobacco advertising should be totally prohibited, that measures should be taken to establish upper limits for emission products of cigarettes, and that governments should develop special programmes to discourage smoking in industries where it is a particular hazard.

Promotion of environmental health

146. In May, the Health Assembly called upon governments to mobilize all possible resources, develop the necessary organizational arrangements, and prepare realistic plans with a view to focusing on priority needs for ensuring safe water and sanitation for all by the year 1990 - the goal set by the United Nations Water Conference for attainment during the period 1980-1990, designated as the International Drinking-Water Supply and Sanitation Decade. 1978 saw efforts on the part of WHO to strengthen technical cooperation with Member States in preparing for the Decade, to promote international cooperation for increasing awareness, priority and flow of external resources for water supply and sanitation, and to enunciate clearly the medium-term programme of environmental health.

147. The method selected for acting on the decisions of the Water Conference was to develop a country-centred approach using regional and global action in support of national objectives. To this end, a steering committee for collaborative action was formed by the agencies of the United Nations system that are concerned with community water supply and sanitation. This committee facilitates the collection, transfer and exchange of programme and project information on Decade activities, including information on country needs and external resources. At the country level, UNDP Resident Representatives coordinate inputs by the United Nations system, with the technical support of WHO and other agencies through their regional and country offices and staff.

148. Additional resources became available in 1978 through cooperation with UNDP, SIDA and the Federal Republic of Germany. These joint activities aim at generating country activities leading to the identification of projects suitable for external investment and to the provision of technical services that will lessen or remove constraints currently hindering development in the water and sanitation sector.

149. Governments' reactions to the resolutions of the Water Conference varied according to individual countries' needs and state of preparedness. Only a few countries are already mobilizing additional resources in order to accelerate their efforts to meet the Decade objectives. However, there are preliminary indications that many governments intend to give the water and sanitation sector high priority in their development plans.

150. By the end of 1978 a rapid assessment of conditions had been completed for about 100 countries, including most of the developing world. Nearly all the reports indicate that further technical cooperation will be needed in the preparatory activities for the Decade.

In order to make its participation more effective, in 1978 the Organization began gradually regionalizing the WHO/World Bank Cooperative Programme, reorienting the activities of staff who will, at the request of Member governments, participate in sector planning and pre-investment activities in preparation for the Decade.

151. Thus, during the International Drinking-Water Supply and Sanitation Decade an all-out effort will be made to provide safe and adequate water supplies and hygienic excreta disposal for all by 1990. For success, realistic plans and programmes must be prepared by the countries concerned, adequate funds must be made available by governments and external sources, and those funds must be deployed to the greatest advantage. The first consultative meeting to discuss how international and bilateral resources can best be mobilized in support of government efforts to reach the targets of the Decade was held in Geneva in November 1978 and was attended by representatives of bilateral agencies, regional banks, and agencies of the United Nations system that will be collaborating during the Decade. Broad agreement was reached on country-level coordination and on immediate action, including regional and national meetings in the near future aimed at influencing programmes and projects at the local level.

152. At the country level, one scheme in the Region of the Americas is well worth noting. Ten Eastern Caribbean countries initiated a system to provide suitable training for all levels of waterworks staff. In the past top- or middle-level personnel were almost always trained outside the Caribbean area, and lack of such staff has hampered the development or improvement of water supplies. The plan put into operation forms part of the wider Caribbean Basic Water Management Project, which benefits from the collaboration of PAHO/WHO and CIDA, aims to be self-sustaining, and may thus be classified as technical cooperation among developing countries. The first phase, during the first five months of 1978, was devoted to "training the trainers", that is, providing technically skilled personnel with educational techniques. Two itinerant instructor teams, composed of West Indian nationals, travelled from island to island and in each conducted a series of three one-week workshops with not more than 15 participants, arranged at times that interfered as little as possible with regular duties. The 140 participants who received this performance-oriented instruction now form a nucleus of staff for training others. In the second half of the year they proceeded with the second phase of the project - the preparation of manuals and aids for practical teaching. They are now developing further useful methodologies in this area.

153. The Health Assembly in May debated the health effects of chemical substances in the environment and requested that international cooperation should be promoted in the evaluation of the health effects of toxic and hazardous chemicals. Subsequently, the first steps were taken to establish an international programme on chemical safety, based on ongoing national and WHO activities and including relevant activities of IARC. In June, a meeting was convened by WHO and the International Council of Scientific Unions to consider the methodology and scientific basis for evaluation. The meeting recommended that a scientific group on this subject should be established under the sponsorship of these two and any other interested organizations. Consultations were also held with a number of Member States who had offered to cooperate; the consultations covered programme content and operational arrangements, the participation of national institutions in the programme, and ways and means of financing the programme. An intergovernmental meeting of representatives of the Member States so far consulted was held in October, at which UNEP was also represented. The meeting provided guidance on the content and organizational structure of the programme and on measures to implement it, including the possible distribution of programme tasks.

Health manpower development

154. No health system can operate effectively unless it is provided with an adequate number of personnel who are trained to deal with the common health problems arising in the community they serve. The Organization's medium-term programme for health manpower development (1978-1983) was presented to the Executive Board in January and to the Health Assembly in May. The programme is the result of teamwork between Member States and WHO and consists of national, regional and global components. It is built on the basic principle that WHO should collaborate with Member States, at their request, in satisfying their health needs through services provided by teams of health personnel, all health activities being undertaken at the most peripheral level of the services as is practicable, by the workers most suitably trained to carry out these activities.

155. The main aim of the programme is to effect a radical change in health manpower development in Member States, making it relevant to present and foreseeable future community health needs. This aim is to be carried out by an integrated process of health services and health manpower development, in which services are planned and developed in order to meet the health needs of entire populations, while health manpower is planned, trained and utilized in order to meet the needs of those services. The first priority of the programme is to contribute to the solution of health problems of developing countries, the second is to orient the development of all categories of health personnel towards satisfying known health needs and the third is to meet the health needs of the most deprived, particularly rural, communities.

156. The Ministerial Consultation on Health Services and Manpower Development held in Teheran, Iran, in February-March provides an illustration of how this programme is being implemented in one of the regions. WHO invited the health and education ministers from 22 countries in the Eastern Mediterranean Region, as well as over 70 health planners and education leaders. The meeting accepted recommendations on the basis of which Member States in the Region, in collaboration with WHO, will develop country-specific mechanisms for the integrated development of health services and health manpower.

157. The Consultation asserted that there must be a national political commitment to the delivery of effective and efficient health care giving adequate coverage to all. Each country must develop its own plan of action, as no solution is universally applicable. The plan must be flexible, subject to constant review, and must be adapted to changing conditions. The following should participate actively in developing the plan: those involved in health services development and the training of all categories of health personnel; those in other development sectors; and the people, who are the "consumers" of health services. The report of the Consultation recommends specific action that Member countries should carry out, and makes specific recommendations on mechanisms, plans and actions for health services and manpower development.

158. The report,[1] widely circulated, may be considered an important landmark in the evolution of effective programmes for health manpower development, closely geared to health service needs, in the countries of the Region. The follow-through of the meeting has been encouraging: several countries have either taken a variety of actions in their health and educational structures with a view to implementing the recommendations of the Consultation, or have requested collaboration in the formulation of integrated policies and programmes in this field. As a direct outcome of the Consultation, for instance, the Governments of Saudi Arabia and Sudan have requested missions specifically to investigate the interrelationships of the health and education sectors in their countries.

Research promotion and development

159. No health system can flourish without the backing of research activities to tackle specific problems and to give general guidance on appropriate developments. Striking progress was made in WHO's programme of research promotion and development in 1978: the whole system was revolutionized, research being made a national activity with the support of the WHO Secretariat. As from its twentieth session, in 1978, the global Advisory Committee on Medical Research was concerned more with global policy than with detailed proposals for specific research. Facing the challenge of identifying the broad issues for health research, the Committee grappled with the problem of making research activities more relevant to people's needs.

160. In 1978 all the regional advisory committees on medical research functioned smoothly, defining regional priorities based on national priorities. To ensure coordination at the global level, the meeting of the global advisory committee brought together the chairmen of the regional advisory committees, whose reports showed that major progress has already been

[1] An integrated approach to health services and manpower development. Report of the Ministerial Consultation on Health Services and Manpower Development, Teheran, 26 February - 2 March 1978. Alexandria, World Health Organization, 1978 (WHO/EMRO Technical Publication No. 1).

made towards recognizing the importance of action-oriented health research, and in developing research programmes relevant to countries' real needs. Table 3 overleaf indicates the way in which the various advisory committees accomplished their tasks. In addition, four subcommittees of the global advisory committee were established to promote further research on health services, nutrition, and diarrhoeal diseases, and to deal with information support to research all four subcommittees met to explore areas that they consider to be of importance.

161. The network of global and regional advisory committees comprises a total of about 100 scientists all over the world who have shown their capacity to identify major health research problems and mount appropriate research programmes. Although the level of priority funding for research programmes remains modest, there is evidence that this network has had a stimulatory effect on biomedical and health services research. Experience from two major global research programmes - the Special Programme of Research, Development and Research Training in Human Reproduction and the Special Programme for Research and Training in Tropical Diseases - clearly demonstrates the possibility of mobilizing major new attacks on the world's health problems by means of carefully prepared, scientifically based programmes.

162. The advisory committees assigned very high priority to health services research, which involves every aspect of the delivery of health services, and favoured its active promotion by WHO in two stages. The first stage concerns developing research capability in various ways: identifying potential research workers from various relevant disciplines, recruiting and training skilled personnel, strengthening institutions to act as national and regional centres for health services, developing basic techniques of use in health services research, and increasing awareness among administrators and scientists of the nature and importance of this field of research. The second stage, following the establishment of research capability, should be concerned with the expansion of this research. Working groups on health services research have been set up in all the WHO regions.

163. Finally, during 1978 the Organization began to formulate a new plan for the management of research activities. The final aim of the plan is to develop the capability of countries in terms of health research, of research resources and support, and of national mechanisms and structures for ensuring adequate national research management. WHO will be active in coordinating the development and implementation of priority health research activities on an international scale and in mobilizing resources for health research. The plan envisages large-scale research built up at the country level and in response to the needs of their people, and progressing through regional to global level, with good coordination of activities among all these levels. The plan is based on two main principles: research activities should form an integral part of programmes and should therefore be managed in the same way as all other programme activities; and emphasis must be laid on the development of national research capabilities, on national determination of research priorities in the light of social health policy, and on national implementation of research activities. The plan may be considered as part of the Organization's current efforts to review its structures in the light of its functions.

Managerial processes for health development

164. The Executive Board in January and the Health Assembly in May considered progress reports on the priority managerial processes for health development: country health programming, medium-term programming, development of programme evaluation, and the information systems programme. The formulation of strategies for attaining an acceptable level of health for all by the year 2000 will require the intensified application of all these processes. Two distinct but closely interlinked aspects are involved, the one relating to national health development and the other to the development of WHO's programme in response to national health development.

165. The lively discussions held in the two governing bodies led to the adoption of several action-oriented resolutions, including an Assembly resolution on managerial processes for health development, which called for the coordinated application of the various processes both for national health development in countries and for programme development in WHO. The regional committees in their 1978 sessions followed up the discussions of the Assembly and stressed the importance of these processes in Member States and in the work of the regional offices.

TABLE 3. IMPORTANT ISSUES DISCUSSED BY THE ADVISORY COMMITTEES ON MEDICAL RESEARCH

Global Advisory Committee
Action-oriented research on nutrition
Research on diarrhoeal diseases
Research on neurological disorders
Safety measures in microbiology
Ethical aspects of WHO's research activities
Health services research
The dissemination of scientific information
The Executive Board's organizational study on "The role of WHO expert advisory panels and committees and collaborating centres in meeting the needs of WHO regarding expert advice and in carrying out technical activities of WHO"
Support (in manpower and financial resources) for WHO's programme of research at national, regional and global levels
African Region
Development of regional research programme
Network of participating centres
Special programme on tropical diseases
Research on malaria and other parasitic diseases
Health services research
Region of the Americas
Nutrition
Environmental health and water supply
Health services research
Communicable diseases including diarrhoea
Ethical aspects of research
South-East Asia Region
Diarrhoeal diseases
Dengue haemorrhagic fever
Leprosy
Malaria
Chronic liver diseases
Delivery of health care
Research on snake-bite
European Region
Health services research
Information systems
Evaluation of new drugs
Drugs for developing countries
Eastern Mediterranean Region
Development of regional medical library and biomedical information centre
Health services research
Appropriate health technology and supply of experimental animals
Research on tropical diseases
Diarrhoeal diseases
Western Pacific Region
Strengthening of national research capability
Coordination of WHO's decentralized research programme
Development of research workers in the field of epidemiology
Nutrition
Diarrhoeal diseases

166. The Executive Board recognized that country health programming is an important tool for national health development in that it helps governments to take political decisions in the spirit of national self-reliance. The Board urged greater collaboration between WHO and Member States in the development of country health programming and in strengthening training activities in this area for both nationals and WHO personnel. The Health Assembly endorsed this assessment of country health programming. The process has evolved over the past five years on the basis of accepted guidelines (currently under revision) and in the light of national experience. By the end of 1978, 35 Member countries had embarked on country health programming, although few have instituted it as a continuing process that is directed from the highest level of their health ministry.

167. The Executive Board, concurring with the methodology used in developing the Organization's medium-term programmes for the implementation of the Sixth General Programme of Work covering a specific period (1978-1983), and in particular with the involvement of Member States in this endeavour, requested the Director-General to continue the development of such programmes and requested the Programme Committee of the Board to continue to review them annually.

168. The medium-term programmes for health manpower development and mental health, the first two medium-term programmes to be prepared by the Organization, were reviewed by the Executive Board and by the Health Assembly. The efforts made to develop a global six-year programme on health manpower development relevant to the needs of Member States constitute an important development, and the Board, recognizing this new form of programme as the product of a continuous dialogue between Member States and the Secretariat, considered that effective monitoring mechanisms should be established at all levels. As regards the mental health programme, the Board found the establishment of groups at national, regional and global levels to provide coordination in both planning and implementation to be an effective approach, and noted with satisfaction the new public health orientation of mental health activities being actively promoted through the programme. Also during 1978, the formulation of the medium-term programme for environmental health was completed, and that of medium-term programmes for the development of comprehensive health services, communicable disease control and non-communicable disease control was begun. All the programmes of the Sixth General Programme of Work will be covered by 1980.

169. Health programme evaluation is being promoted on the basis of guidelines that were endorsed by the Executive Board in January and by the Health Assembly in May. These guidelines have been disseminated to Member States, and the regional offices are initiating trial applications in a number of countries. The guidelines are also being progressively introduced within WHO for the evaluation of its programmes.

170. National health information systems are a complex issue, since they serve a wide variety of purposes, including the support of the national health development process, the management of health institutions, and the conduct of biomedical and health services research. Draft guidelines were being prepared in 1978 for the development of national health information systems. The key components of the WHO information system, on the other hand, were fully operational, and additional components such as the international exchange of health and related information were being developed.

Conclusion

171. In short, 1978 was an extremely eventful and active year for the Organization. The general direction of activity was centrifugal. In other words, attention was focused on the question of how WHO should be developing, and the emphasis was less on headquarters than on the regions, and less on the regional offices than on Member States, with much greater use of national personnel and national institutions to further the aims of WHO.

172. If the climax of 1977 was the adoption by the World Health Assembly of the aim of health for all by the year 2000, then the climax of 1978 was the sequel to that decision, namely the Declaration of Alma-Ata, which asserts that primary health care is the key to attaining the target that has been set. All the related issues were thoroughly debated at the Alma-Ata Conference and clearly expressed in the Declaration, and WHO's programmes are now being geared accordingly.

173. However, the target cannot be reached by WHO alone, no matter how well it fulfils its constitutional function as the directing and coordinating authority on international health work, and no matter how much it is involved in technical cooperation with its Member States. The primary impetus must come from the countries themselves, who must display the determined political will without which little can be achieved. The road to health for all by the year 2000 will be a long and arduous one. But the first steps have been taken.

ANNEX 5

PROGRAMME SUPPORT COSTS

/from A32/21 Add.1 - 3 April 1979/

Report by the Director-General[1]

1. As previously reported to the Health Assembly and the Executive Board, the Governing Council of the United Nations Development Programme (UNDP) in 1975 approved, for the years 1974-1977, the reimbursement of executing agencies for support costs (or overhead costs) relating to UNDP-financed activities at the rate of 14% of actual project expenditures. In 1977 the Governing Council decided to continue the existing arrangements for the reimbursement for support costs at the rate of 14% of project expenditures for the years 1978 and 1979. It also decided to establish an Intergovernmental Working Group on Support Costs to study the question of future reimbursement arrangements.

2. In response to the Governing Council's invitation, the Director-General of WHO has cooperated fully with this Working Group by providing all relevant information on the Organization's position requested by the Working Group for the purpose of its comprehensive examination of the various aspects of this complex matter. He has also actively cooperated with the executive heads of the other organizations in the United Nations system within the Administrative Committee on Coordination (ACC) with a view to the formulation and submission to the Working Group of joint comments on certain preliminary proposals for a new system for agency support costs made by the Joint Inspection Unit (JIU).

3. In the second half of 1978 the Administrator of UNDP, at the request of the above-mentioned Working Group, and in collaboration with the executing agencies, developed a proposed modified formula for the reimbursement of agency support costs. The new basic elements of this proposal related to: (i) a regressive scale of reimbursements after annual UNDP-financed project expenditures of an executing agency reached certain specified levels, beginning with US$ 50 million, on the grounds of "economies of scale"; and (ii) the application of a lower rate of reimbursement (7%) to UNDP-financed projects comprising 75% or more of equipment and/or subcontract components.

4. When the Intergovernmental Working Group on Support Costs considered the Administrator's report on this matter in January 1979, it was informed that most of the executive heads in ACC would have been prepared to agree to a modified support cost reimbursement formula along the lines proposed by the Administrator and to submit such a proposal to their respective legislative bodies for consideration. However, the executive heads of two organizations had entered strong reservations on the principle of negative adjustments in support cost reimbursements for economies of scale as well as on any changes in the existing arrangements which would result in an increase in the amounts of support costs that would have to be borne by their organizations' regular (assessed) budgets. Consequently, it had not proved possible for the organizations in the United Nations system to reach a consensus on this issue.

[1] Submitted in connexion with agenda item 3.10.1 (Collaboration with the United Nations system - General matters). No resolution or decision was adopted on this subject.

5. At its January 1979 session the Intergovernmental Working Group also had before it a report containing the comments of the Advisory Committee on Administrative and Budgetary Questions (ACABQ) on the modified formula for support cost reimbursements proposed by the Administrator of UNDP. In its comments, ACABQ expressed its appreciation of the Administrator's efforts to work out a generally acceptable formula. However, it was not convinced that the proposed modified formula could be regarded as meeting the criterion of general acceptability, and also pointed out that it had not been proved that this formula had significant advantages, on technical grounds, over the present approach of applying a uniform (14%) reimbursement formula. The key point, stressed on more than one occasion by ACABQ and other bodies, is that as Member States have different views on the role of assessed budgets in the field of technical cooperation, it is essential to bring to the attention of the legislative bodies in the United Nations system the probable financial implications of accepting a modified formula for reimbursement for support costs of activities financed from extrabudgetary funds.

6. The Intergovernmental Working Group on Support Costs decided to continue its consideration of this matter immediately prior to the June 1979 session of the UNDP Governing Council. In the meantime, it requested all executing agencies to supply certain additional information, in particular the estimated financial impact which the proposed modified formula would have on their support cost reimbursements. Since the intention is that any future reimbursement formula should be uniformly applied to all extrabudgetary activities, and not just to those financed by UNDP, the data in question would relate to all sources of funds other than the regular budget. The object of this exercise is to determine the total amounts of support costs relating to extrabudgetary activities which, if the proposed modified reimbursement formula were applied, the regular (assessed) budgets of the organizations in the United Nations system might have to assume over and above the amounts of such costs now being met from their regular budgets. In the case of WHO, it has been estimated that during the period under consideration (1982-1986) the application of a modified support cost formula along the lines proposed could result in a reduction in annual reimbursements for such costs, relating only to UNDP-financed activities executed by WHO, ranging from US$ 250 000-$ 325 000 in 1982 to US$ 425 000-$ 550 000 in 1986, and, under all extrabudgetary sources of funds, an estimated annual reduction ranging from US$ 1.7 million - $ 2.2 million in 1982 to US$ 2.9 million - $ 3.8 million in 1986.

7. The Director-General will report on further developments in this matter to the Executive Board and the Health Assembly.

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Mr A. N. MOLTENI, Counsellor, Permanent Mission of the Republic of Argentina to the United Nations Office and the Other International Organizations at Geneva

AUSTRALIA

Delegates

Mr R. J. HUNT, Minister for Health (Chief Delegate)

Dr G. HOWELLS, Director-General of Health, Department of Health (Deputy Chief Delegate)

Dr R. W. CUMMING, Assistant Director-General, International Health Branch, Department of Health[1]

Alternates

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Mr M. A. S. LANDALE, First Secretary, Permanent Mission of Australia to the United Nations Office and the Other International Organizations at Geneva

Advisers

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AUSTRIA

Delegates

Dr A. KRASSNIGG, Director-General of Public Health, Federal Ministry of Health and Environmental Protection (Chief Delegate)

Dr J. DAIMER, Deputy Director-General of Public Health, Federal Ministry of Health and Environmental Protection[4]

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Dr Sieglinde WEINBERGER, Federal Ministry of Health and Environmental Protection

Dr W. LANG, Counsellor, Deputy Permanent Representative of Austria to the United Nations Office and the Specialized Agencies at Geneva

Dr M. SAJDIK, Secretary of Embassy, Permanent Mission of Austria to the United Nations Office and the Specialized Agencies at Geneva

[1] Chief Delegate from 12 May.

[2] Deputy Chief Delegate from 12 May.

[3] Delegate from 12 May.

[4] Chief Delegate from 11 May.

BAHRAIN

Delegates

Dr A. M. FAKHRO, Minister of Health (Chief Delegate)

Dr E. YACOUB, Assistant Under-Secretary for Technical Affairs, Ministry of Health (Deputy Chief Delegate)

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BANGLADESH

Delegates

Professor A. Q. M. B. CHOUDHURY, Deputy Prime Minister in charge of the Ministry of Health and Population Control (Chief Delegate)

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Mr M. K. ANWAR, Secretary, Health Division, Ministry of Health and Population Control

Advisers

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Mr N. CHOWDHURY, Second Secretary, Permanent Mission of the People's Republic of Bangladesh to the United Nations Office and Other International Organizations at Geneva

BELGIUM

Delegates

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Mr P. NOTERDAEME, Ambassador, Permanent Representative of Belgium to the United Nations Office and the Specialized Agencies at Geneva (Deputy Chief Delegate)

Mr A. BERWAERTS, Inspecteur-chef de service, Ministry of Public Health and Family Welfare

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Advisers

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BENIN

Delegates

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BOLIVIA

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BOTSWANA

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BRAZIL

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Adviser

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BULGARIA

Delegates

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[1] Chief Delegate from 14 May.

BURMA

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BURUNDI

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Mrs M. CÔTÉ, Adviser, Health Services Administration, Department of National Health and Welfare
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Dr C. A. VIEIRA RAMOS, Health Affairs Delegate for Brava, Ministry of Health and Social Affairs

CENTRAL AFRICAN EMPIRE

Delegates

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Dr S. FEIKOUMON, Chief, Basic Health Service; Project Coordinator

CHAD

Delegates

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Dr A. TOURÉ, Ministry of Public Health

CHILE

Delegates

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[1] Chief Delegate from 14 May.

[2] Delegate from 14 May.

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Mr GAN Xinfa, Bureau of Public Health, Shanghai
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COLOMBIA

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COMOROS

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Mr G. CHARLES, Head, Department of Multilateral Cooperation, Ministry of Foreign Affairs
Dr C. ABBAS, Chief Physician, Medical District of Grande-Comore

CONGO

Delegates
Mr P. D. BOUSSOUKOU-BOUMBA, Minister of Health and Social Affairs (Chief Delegate)
Dr B. LOEMBE, Secretary-General of Public Health, Ministry of Health and Social Affairs
Mr J. de D. OBOUAKA, Director of Pharmacies, Ministry of Health and Social Affairs

COSTA RICA

Delegates
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Mr M. FREER, Ambassador, Permanent Representative of the Republic of Costa Rica to the United Nations Office and the Other International Organizations at Geneva (Deputy Chief Delegate)

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Alternate

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CUBA

Delegates

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Alternates

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Adviser

Mrs T. de J. FERNÁNDEZ DÍAZ, Directorate of Non-aligned Countries and Special Conferences, Ministry of External Relations

CYPRUS

Delegates

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CZECHOSLOVAKIA

Delegates

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Professor J. PROKOPEC, Minister of Health of the Czech Socialist Republic (Deputy Chief Delegate)[1]

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Alternates

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Mr J. JIRŮŠEK, Third Secretary, Permanent Mission of the Czechoslovak Socialist Republic to the United Nations Office and the Other International Organizations at Geneva

DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

Delegates

Dr LI Jong Ryul, First Vice-Minister, Ministry of Public Health (Chief Delegate)

Dr KANG Yong Jun, Bureau of Foreign Relations, Ministry of Public Health

Dr CHOE Tae Sop, Researcher, Academy of Medical Science of Korea

Alternate

Mr PAK Il Bu, Second Secretary, Permanent Delegation of the Democratic People's Republic of Korea to the International Organizations at Geneva

DEMOCRATIC YEMEN

Delegates

Dr A. S. I. BAMATRAF, Deputy Minister of Public Health (Chief Delegate)

Dr G. A. ISMAIL, Director-General of Public Health, Ministry of Public Health

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[1] Chief Delegate from 14 May.

[2] Delegate from 14 May.

DENMARK

Delegates
- Dr S. K. SØRENSEN, Director-General of the National Health Service (Chief Delegate)
- Mr G. A. LUSTRUP, Deputy Permanent Under-Secretary, Ministry of the Interior (Deputy Chief Delegate)
- Dr N. ROSDAHL, Deputy Director-General, National Health Service[1]

Alternates
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- Mr J. V. LARSEN, Head of section, Ministry of the Interior

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- Mr N. J. LASSEN, Acting Head of Division, Ministry of Foreign Affairs
- Dr E. LAURIDSEN, Consultant, Ministry of Foreign Affairs
- Mr M. WAGTMANN, First Secretary, Permanent Mission of Denmark to the United Nations Office and the Other International Organizations at Geneva

DJIBOUTI

Delegates
- Mr M. A. ISSA, Minister of Public Health and Social Affairs (Chief Delegate)
- Dr A. ABSIEH, Director of Public Health

ECUADOR

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- Mr O. EL-SHAFEI, Ambassador, Permanent Representative of the Arab Republic of Egypt to the United Nations Office and the Specialized Agencies at Geneva (Deputy Chief Delegate)
- Dr A. N. SIRRY, First Under-Secretary of State, Ministry of Health

Alternates
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- Dr A. A. EL GAMAL, Under-Secretary of State, Ministry of Health
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- Mr F. EL-IBRASHI, Minister Plenipotentiary, Permanent Mission of the Arab Republic of Egypt to the United Nations Office and the Specialized Agencies at Geneva
- Dr I. BASSIOUNI, Director-General, Department of Foreign Health Relations, Ministry of Health
- Mr M. OMAR, First Secretary, Permanent Mission of the Arab Republic of Egypt to the United Nations Office and the Specialized Agencies at Geneva
- Mr T. DINANA, First Secretary, Permanent Mission of the Arab Republic of Egypt to the United Nations Office and the Specialized Agencies at Geneva
- Dr E. S. H. EL BERMAWY, Director-General of Supervision and Follow-up Department, Ministry of Health

EL SALVADOR

Delegates
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ETHIOPIA

Delegates

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FIJI

Delegate

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FINLAND

Delegates

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Mr A. YANA, Chargé de mission, Ministry of the Environment and Environmental Development

GABON

Delegates

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GAMBIA

Delegates

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GERMAN DEMOCRATIC REPUBLIC

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GERMANY, FEDERAL REPUBLIC OF

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Mr J. MÖHLING, Counsellor, Section for the United Nations Specialized Organizations and Multilateral Cooperation, Federal Ministry for Economic Cooperation

[1] Chief Delegate from 18 May.

[1] Delegate from 16 May.

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Adviser
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GHANA

Delegates
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Mr T. R. D. ADDAE, Principal Secretary, Ministry of Health

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GREECE

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[1] Chief Delegate from 10 May.

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GUATEMALA

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GUINEA

Delegates
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Alternate
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GUINEA-BISSAU

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GUYANA

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Dr T. R. JONES, Chief Medical Officer, Ministry of Health, Housing and Labour

HAITI

Delegates
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HUNGARY

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Mr L. KOLONICS, Deputy Head of Department, Ministry of Health
Mr B. BLAHÓ, Deputy Head of Department, Ministry of Health
Dr L. ÉLIÁS, Deputy Head of Section, Ministry of Health
Mr J. VARGA, First Secretary, Permanent Mission of the Hungarian People's Republic to the United Nations Office and the Other International Organizations at Geneva
Mrs L. OLASZ, Second Secretary, Ministry of Foreign Affairs

ICELAND

Delegates
Mr M. H. MAGNÚSSON, Minister of Health and Social Security (Chief Delegate)
Dr P. SIGURDSSON, Secretary General, Ministry of Health and Social Security (Deputy Chief Delegate)
Dr O. OLAFSSON, Chief Medical Officer, Ministry of Health and Social Security

Alternates
Dr O. BJARNASON, Chief Medical Officer for School Health and Community Medicine, Ministry of Health and Social Security
Mr T. KARLSSON, Counsellor, Deputy Permanent Representative of Iceland to the United Nations Office and the Other International Organizations at Geneva

Adviser
Mr H. H. KRÖYER, Ambassador, Permanent Representative of Iceland to the United Nations Office and the Other International Organizations at Geneva

INDIA

Delegates
Mr R. RAY, Minister for Health and Family Welfare (Chief Delegate)

Mr R. PRASAD, Secretary, Ministry of Health and Family Welfare (Deputy Chief Delegate)
Dr B. SANKARAN, Director General of Health Services, Ministry of Health and Family Welfare

Advisers
Mr N. N. VOHRA, Joint Secretary, Ministry of Health and Family Welfare
Mr R. K. BHUJABAL, Special Assistant to the Minister for Health and Family Welfare
Mr K. S. SODHI, First Secretary, Permanent Mission of India to the United Nations Office and the Other International Organizations at Geneva

INDONESIA

Delegates
Dr SUWARDJONO SURJANINGRAT, Minister of Health (Chief Delegate)
Professor A. A. LOEDIN, Head, National Health Research and Development Institution, Ministry of Health (Deputy Chief Delegate)[1]
Dr W. BAHRAWI, Inspector General, Ministry of Health

Alternate
Dr HAPSARA, Head, Planning Bureau, Secretariat General of the Ministry of Health

Advisers
Mr M. SIDIK, Minister Counsellor, Permanent Mission of the Republic of Indonesia to the United Nations Office and the Other International Organizations at Geneva
Mr A. NASIER, Third Secretary, Permanent Mission of the Republic of Indonesia to the United Nations Office and the Other International Organizations at Geneva

IRAN

Delegates
Dr K. SAMI, Minister of Health and Welfare (Chief Delegate)
Dr S. A. KHOSROWSHAHI, Director-General, International Health Relations Department, Ministry of Health and Welfare (Deputy Chief Delegate)
Dr S. OURSHANO OLGHI, Director, Department of Parasitic and Infectious Enteric Diseases, Ministry of Health and Welfare

Adviser
Dr G. A. LEYLIABADI, Under-Secretary of State for Planning and Control of Programmes, Ministry of Health and Welfare

IRAQ

Delegates
Dr R. I. HUSAIN, Minister of Health (Chief Delegate)
Dr S. Y. MICHAEL, Consultant to the Ministry of Health
Dr A. S. HASSOUN, Director of International Health Relations, Ministry of Health

Alternates
Dr N. H. A. AL-SHABANDER, Chief Medical Officer, Governorate of Basrah, Ministry of Health
Dr M. Y. A. AL-HOSSAINI, Deputy Director-General of Preventive Medicine, Ministry of Health
Dr A. W. K. H. AL-BAYATI, Assistant President of the Medical City, Ministry of Health
Mr F. B. AL-TIKRITI, First Secretary, Permanent Mission of the Republic of Iraq to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Mr M. A. HUSSAIN, Second Secretary, Permanent Mission of the Republic of Iraq to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

IRELAND

Delegates
Mr C. J. HAUGHEY, Minister for Health and Social Welfare (Chief Delegate)
Mr S. GAYNOR, Ambassador, Permanent Representative of Ireland to the United Nations Office and to the Specialized Agencies at Geneva

[1] Chief Delegate from 12 May.

Dr J. H. WALSH, Deputy Chief Medical Officer, Department of Health

Alternates

Mr J. O'SULLIVAN, Assistant Secretary, Department of Health

Mr J. O'CONNOR, Assistant Principal, Department of Health

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ISRAEL

Delegates

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Professor J. MENCZEL, Head, Department of Medicine, Hadassah Hospital, Mount Scopus (Deputy Chief Delegate)[1]

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Alternates

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Professor M. SHANI, Director-General, Ministry of Health

Mr S. KATZ, Assistant Director, International Organizations Division, Ministry of Foreign Affairs

Dr G. KEISAR, Chief, External Relations, Ministry of Health

Dr Y. WAYSBORT, Director Hospitalization Services, Ministry of Health

Mr H. S. AYNOR, Ambassador, Director of the Africa Division, Ministry of Foreign Affairs

Advisers

Mrs R. RAELI, Counsellor, Permanent Mission of Israel to the United Nations Office and the Specialized Agencies at Geneva

Mr D. GAL, Counsellor, Ministry of Foreign Affairs

[1] Chief Delegate from 13 May.

[2] Deputy Chief Delegate from 13 May.

[3] Delegate from 13 May.

ITALY

Delegates

Mrs T. ANSELMI, Minister of Health (Chief Delegate)

Professor R. VANNUGLI, Director, Office of International Relations, Ministry of Health (Deputy Chief Delegate)[4]

Professor L. GIANNICO, Director-General of Public Health, Ministry of Health

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Professor A. ARDIGO, President of the Technical Committee, Research Centre, Ministry of Health

Professor F. POCCHIARI, Director, Istituto Superiore di Sanità

Professor D. POGGIOLINI, Director-General, Pharmaceutical Service, Ministry of Health

Professor M. MARLETTA, Director-General, Ministry of Health

Professor G. A. CANAPERIA, President, Italian World Health Centre

Professor B. PACCAGNELLA, Director, Institute of Hygiene, University of Padua

Professor G. PENSO, Istituto Superiore di Sanità

Dr F. L. ODDO, Chief Medical Inspector General, Ministry of Health

Mr G. ARMENTO, Treasury Official

Dr A. MOLFESE, International Relations Bureau, Ministry of Health

Advisers

Professor S. NORDIO, Director, Institute of Paediatrics, University of Trieste

Professor B. SALVADORI, Director, Clinic of Obstetrics and Gynaecology, University of Parma

Dr F. BIANCHINI, Ministry of Health

Dr M. BERTOLINI, Ministry of Health

Dr G. LOJACONO, Institute of Economic Research and Programming

Miss M. T. FALCETTA, Attaché, Permanent Mission of Italy to the United Nations Office and the Other International Organizations at Geneva

[4] Chief Delegate from 9 May.

[5] Delegate from 9 May.

IVORY COAST

Delegates

Mr J.-B. MOCKEY, Minister of State for Public Health and Population (Chief Delegate)

Mr A. ESSY, Ambassador, Permanent Representative of the Republic of the Ivory Coast to the United Nations Office and the Specialized Agencies at Geneva and Vienna (Deputy Chief Delegate)

Dr I. KONE, Director of Regional and International Relations, Ministry of Public Health and Population

Alternates

Mr C. BOUAH, Counsellor, Permanent Mission of the Republic of the Ivory Coast to the United Nations Office and the Specialized Agencies at Geneva and Vienna

Miss M.-L. BOA, First-Secretary, Permanent Mission of the Republic of the Ivory Coast to the United Nations Office and the Specialized Agencies at Geneva and Vienna

JAMAICA

Delegates

Dr D. MANLEY, Minister of Health and Environmental Control (Chief Delegate)

Dr A. Wynante PATTERSON, Chief Medical Officer, Ministry of Health and Environmental Control

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Alternates

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Mrs L. PARKINS, Personal Assistant to the Minister of Health and Environmental Control

JAPAN

Delegates

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Alternates

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JORDAN

Delegates

Mr A. R. RAWABDEH, Minister of Health (Chief Delegate)

Dr N. HMOUD, Director of Health, Zerka

Dr A. YAGHLIAN, Director of Foreign Affairs, Ministry of Health

Alternate

Dr F. HALASEH, Director of Health, Ma'an

KENYA

Delegates

Mr J. C. N. OSOGO, Minister for Health (Chief Delegate)

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Dr J. A. ALUOCH, Director of Tuberculosis Investigations Centre, Ministry of Health

Alternates

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Mrs T. M. ODUORI, Nursing Officer, Ministry of Health

KUWAIT

Delegates

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Dr A. AL-SAIF, Department of Public Health, Ministry of Public Health

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Adviser
Mr M. F. TAWFIK, Legal Adviser, Ministry of Public Health

LAO PEOPLE'S DEMOCRATIC REPUBLIC

Delegates
Dr K. PHOLSENA, Secretary of State for Public Health (Chief Delegate)
Dr K. SOUVANNAVONG, Director of Finance and Planning, Ministry of Public Health

LEBANON

Delegates
Dr R. SAADÉ, Director-General, Ministry of Public Health (Chief Delegate)
Mr M. HALLAB, Chief, Sanitary Engineering Department, Ministry of Public Health
Mr V. BITAR, First Secretary, Permanent Mission of Lebanon to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

LESOTHO

Delegates
Mr P. MOTA, Minister of Health and Social Welfare (Chief Delegate)
Mr M. T. THABANE, Permanent Secretary for Health and Social Welfare
Dr L. M. MOHAPELOA, Senior Medical Officer of Mental Health

Adviser
Dr M. C. MOKETE, Head, Department of Ophthalmology, Queen Elizabeth II Central Hospital

LIBERIA

Delegates
Dr Kate BRYANT, Minister of Health and Social Welfare (Chief Delegate)
Dr W. S. BOAYUE, Deputy Minister, Chief Medical Officer, Ministry of Health and Social Welfare (Deputy Chief Delegate)
Dr E. DENNIS, Director, Liberian Institute for Biomedical Research

Alternate
Dr S. V. FREEMAN, Ministry of Health and Social Welfare

LIBYAN ARAB JAMAHIRIYA

Delegates
Dr A. M. ABDULHADI, Under-Secretary of Health (Chief Delegate)
Dr S. AZZUZ, Attaché for WHO Affairs, Permanent Mission of the Socialist People's Libyan Arab Jamahiriya to the United Nations Office at Geneva and the Specialized Agencies in Switzerland (Deputy Chief Delegate)
Dr F. EL-GERBI, Assistant Secretary for Technical Affairs, Educational Health Facilities; Director-General of Hospitals, Benghazi

Alternate
Mr A. BABA, National Health Administration

LUXEMBOURG

Delegates
Mr E. KRIEPS, Minister of Public Health (Chief Delegate)
Dr E. DUHR, Director of Public Health (Deputy Chief Delegate)
Mr J. RETTEL, Ambassador, Permanent Representative of Luxembourg to the United Nations Office and the Specialized Agencies at Geneva

Alternates
Dr J. KOHL, Médecin-inspecteur, Directorate of Public Health
Mrs J. ANCEL-LENNERS, Deputy Permanent Representative of Luxembourg to the United Nations Office and the Specialized Agencies at Geneva

MADAGASCAR

Delegates
Dr E. RIBAIRA, Director of Public Health and Social Hygiene, Ministry of Health (Chief Delegate)
Mr J. RASOLOFONIRINA, Chief, Evaluation and Planning Division, Ministry of Health
Dr R. RAMAHATRA, Chief, Provincial Health Service of Tamatave

MALAWI

Delegates
Mr L. J. CHIMANGO, Minister of Health (Chief Delegate)
Mr L. B. MALUNGA, Principal Secretary for Health, Ministry of Health
Dr D. CHILEMBA, Chief Medical Officer, Ministry of Health

MALAYSIA

Delegates
Mr CHONG Hon-Nyan, Minister of Health (Chief Delegate)
Dr A. K. SAHAN, Director of Training and Manpower Development, Ministry of Health (Deputy Chief Delegate)
Dr LIM Ewe-Seng, Deputy Director, Planning and Development Division, Ministry of Health

Alternates
Mr M. R. ABDUL KARIM, Principal Assistant Secretary, Ministry of Health
Mr S. N. KAMARULZAMAN, Second Secretary, Permanent Mission of Malaysia to the United Nations and the Other International Organizations at Geneva

MALDIVES

Delegates
Mr M. M. HUSSAIN, Minister of Health (Chief Delegate)
Mrs A. A. SATTAR, Sister-in-Charge, Government Hospital, Malé

MALI

Delegates
Mr M. KONE, Minister of Public Health and Social Affairs (Chief Delegate)
Dr A. DIALLO, Director-General of Public Health, Ministry of Public Health and Social Affairs
Mr M. KONARE, Chief, Cultural and Social Cooperation Section, Ministry of Foreign Affairs and International Cooperation

MALTA

Delegates
Dr V. MORAN, Minister of Health and Environment (Chief Delegate)
Dr A. GRECH, Chief Government Medical Officer, Ministry of Health and Environment (Deputy Chief Delegate)
Mr A. DEBONO, Private Secretary to the Minister of Health and Environment

Alternate
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MAURITANIA

Delegates
Dr Y. DIAGANA, Minister of Labour, Health and Social Affairs (Chief Delegate)[1]
Dr M. S. OULD ZEIN, Director of Health Services, Ministry of Labour, Health and Social Affairs

MAURITIUS

Delegates
Mr M. TEELUCK, Minister of Health (Chief Delegate)
Dr A. Y. WONG Shiu Leung, Chief Medical Officer, Ministry of Health

MEXICO

Delegates
Dr E. MARTÍNEZ MANAUTOU, Secretary for Health and Welfare (Chief Delegate)
Dr R. ÁLVAREZ GUTIÉRREZ, Director-General of International Affairs, Secretariat for Health and Welfare
Dr A. FUJIGAKI LECHUGA, Director-General of Epidemiology, Secretariat for Health and Welfare

Alternate
Mr J. L. VALLARTA, Minister Counsellor, Deputy Permanent Representative of Mexico to the United Nations Office at Geneva and the Other International Organizations in Switzerland

[1] From 7 to 13 May.

MONACO

Delegates

Dr E. BOÉRI, Technical Adviser, Permanent Delegate of the Principality of Monaco to the International Health Organizations (Chief Delegate)

Mr D.-L. GASTAUD, Director, Action sanitaire et sociale

MONGOLIA

Delegates

Dr D. NYAM-OSOR, Minister of Public Health (Chief Delegate)

Dr T. RINCHINDORJ, Head, Foreign Relations Division, Ministry of Public Health

Dr R. ARSLAN, Foreign Relations Division, Ministry of Public Health

Alternate

Mr S. DAVAA, Third Secretary, Permanent Mission of the People's Republic of Mongolia to the United Nations Office at Geneva and the Other International Organizations

MOROCCO

Delegates

Dr R. RAHALLI, Minister of Public Health (Chief Delegate)

Mr M. A. SKALLI, Ambassador, Permanent Representative of the Kingdom of Morocco to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Mr O. JENNANE, Secretary-General, Ministry of Public Health

Alternates

Professor M. TAHAR ALAOUI, Director of Technical Affairs, Ministry of Public Health

Mr M. FERAA, Inspector-General of Public Health, Ministry of Public Health

Dr A. JOUHARI-OUARAINI, Director of the Office of the Minister of Public Health

Dr N. FIRKI BENBRAHIM, Chief, Division of Epidemiology, Ministry of Public Health

Dr O. AKALAY, Chief Physician, Medical Province of Agadir

Dr D. ARCHANE, Mohamed V Hospital, Rabat

Dr A. MAAOUNI, Professor, Rabat Faculty of Medicine

Dr N. BENOMAR, Chief Medical Officer, Rabat-Salé Medical Prefecture

Mr H. TADOT, Chief, Office of the Minister of Public Health

Mr J. CHEICK LAHLOU, Member of the National Council of the Order of Pharmacists

Mr A. CHAWKI, Member of the National Council of the Order of Pharmacists

Mr A. BOJJI, Second Secretary, Permanent Mission of the Kingdom of Morocco to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

MOZAMBIQUE

Delegates

Dr H. F. B. MARTINS, Minister of Health (Chief Delegate)

Dr A. J. R. CABRAL, Director of Preventive Medicine, Ministry of Health (Deputy Chief Delegate)

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Alternates

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Dr Maria Beatriz COSTA, Officer for International Organizations, Secretariat for International Cooperation, Ministry of Health

Mrs A. M. A. NHANCALE, Secretariat for International Cooperation, Ministry of Health

NEPAL

Delegates

Mr P. S. LAWOTI, Minister of Health (Chief Delegate)

Dr L. POUDAYL, Director-General of Health Services, Ministry of Health

NETHERLANDS

Delegates

Mrs E. VEDER-SMIT, State Secretary of Health and Environmental Protection (Chief Delegate)

Dr P. SIDERIUS, Secretary-General, Ministry of Health and Environmental Protection

Dr J. SPAANDER, Director-General, National Institute of Public Health

Alternates

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Mr M. W. H. CROM, Ministry of Foreign Affairs
Mr H. MENALDA VAN SCHOUWENBURG, Division of International Affairs, Ministry of Health and Environmental Protection

Adviser
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NEW ZEALAND

Delegates
Mr G. F. GAIR, Minister of Health (Chief Delegate)
Dr H. J. H. HIDDLESTONE, Director-General of Health, Department of Health
Dr R. C. BEGG, Deputy Director, Public Health Division, Department of Health

Alternates
Mr R. M. RICHARDS, Deputy Permanent Representative of New Zealand to the United Nations Office at Geneva
Mr D. I. WHITE, Third Secretary, Permanent Mission of New Zealand to the United Nations Office at Geneva
Mr E. P. ROGERS, Private Secretary to the Minister of Health

NICARAGUA

Delegate
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NIGER

Delegates
Dr Y. TOUNKARA, Minister of Public Health and Social Affairs (Chief Delegate)
Dr L. LOCO, Secretary-General, Ministry of Public Health and Social Affairs (Deputy Chief Delegate)
Dr J. ALFA CISSÉ, Directeur de l'Hygiène et de la Médecine mobile, Ministry of Public Health and Social Affairs

Alternates
Dr I. ABDOU, Director of Health Care Institutions, Ministry of Public Health and Social Affairs
Dr M. DAGA, Departmental Director of Health for Tahoua, Ministry of Public Health and Social Affairs

NIGERIA

Delegates
Dr P. M. OGBANG, Federal Commissioner for Health, Federal Ministry of Health and Social Welfare (Chief Delegate)
Mr E. O. OMOYELE, Permanent Secretary, Federal Ministry of Health and Social Welfare (Deputy Chief Delegate)
Dr I. O. N. NSOLO, Director of Medical Services and Training, Federal Ministry of Health and Social Welfare

Alternates
Dr P. O. EMAFO, Chief Pharmacist, Federal Ministry of Health and Social Welfare
Dr (Mrs) M. O. AROMASODU, Assistant Director of Public Health Services, Federal Ministry of Health and Social Welfare
Mr S. A. ILO, Under-Secretary (Institutions and External Organizations), Federal Ministry of Health and Social Welfare
Professor P. I. AKUBUE, Lecturer/Pharmacist, University of Nigeria
Dr I. H. MANGGA, Principal Medical Officer for Planning, Federal Ministry of Health and Social Welfare
Dr M. L. MALGWI, Acting Principal Medical Officer; Consultant Physican for Mubi Medical Area

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Mr T. S. O. OLUMOKO, First Secretary, Permanent Mission of the Federal Republic of Nigeria to the United Nations Office and the Other International Organizations at Geneva

NORWAY

Delegates
Dr T. MORK, Director-General of Health Services (Chief Delegate)
Mr F. MELLBYE, Commissioner of Health
Dr H. DØLVIK, Commissioner of Health

Alternates
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Dr Ø. ROLSTAD, County Health Officer

Advisers
Mr O. GRAHAM, Counsellor, Permanent Mission of Norway to the United Nations Office and the Other International Organizations at Geneva
Mr N. O. STAVA, First Secretary of Embassy, Permanent Mission of Norway to the United Nations Office and the Other International Organizations at Geneva

OMAN

Delegates
Dr M. AL KHADURI, Minister of Health (Chief Delegate)
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Alternates
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Mr A. A. SALEH, Senior Administrative Officer, Ministry of Health

PAKISTAN

Delegates
Dr S. HASAN, Deputy Director-General of Health, Ministry of Health (Chief Delegate)
Mr A. A. HASHMI, Second Secretary, Permanent Mission of the Islamic Republic of Pakistan to the United Nations Office and the Specialized Agencies at Geneva

[1] Chief Delegate from 21 May.

PANAMA

Delegates
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Dr C. BRANDARIZ, Director, Epidemiological Service, Ministry of Health
Dr O. FERRER-ANGUIZOLA, Ambassador, Permanent Representative of Panama to the United Nations Office at Geneva

Adviser
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PAPUA NEW GUINEA

Delegates
Mr R. DOA, Minister for Health (Chief Delegate)
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Alternate
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PARAGUAY

Delegates
Dr A. GODOY JIMÉNEZ, Minister of Public Health and Social Welfare (Chief Delegate)
Dr R. M. CÁCERES ALDERETE, Director-General of the Ministry of Public Health and Social Welfare

PERU

Delegates
Mr E. RIVASPLATA HURTADO, Minister of Health (Chief Delegate)
Professor F. SÁNCHEZ MORENO, Director-General of the Office of the Minister of Health
Dr Rosa Esther SILVA Y SILVA, Counsellor, Permanent Mission of Peru to the United Nations Office and the Other International Organizations at Geneva

Alternates

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Mr A. GÁLVEZ DE RIVERO, Second Secretary, Permanent Mission of Peru to the United Nations Office and the Other International Organizations at Geneva

PHILIPPINES

Delegates

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POLAND

Delegates

Professor M. SLIWINSKI, Minister of Health and Social Welfare (Chief Delegate)

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Alternates

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Professor B. LEWARTOWSKI, Director, Warsaw School for Postgraduate Medical Education

Mr B. MUSIELAK, Adviser to the Minister of Foreign Affairs

Advisers

Mrs I. GLOWACKA, Chief of Section, Department of International Relations, Ministry of Health and Social Welfare

Mrs B. BITNER, Counsellor, Department of International Relations, Ministry of Health and Social Welfare

PORTUGAL

Delegates

Mr A. DE CARVALHO, Ambassador, Permanent Representative of Portugal to the United Nations Office and the Other International Organizations at Geneva (Chief Delegate)

Mr L. DE OLIVEIRA NUNES, Minister Plenipotentiary, Deputy Permanent Representative of Portugal to the United Nations Office and the Other International Organizations at Geneva (Deputy Chief Delegate)

Professor L. A. CAYOLLA DA MOTTA, Director, Bureau of Studies and Health Planning, Ministry of Social Affairs

Alternates

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Professor A. A. DE CARVALHO SAMPAIO, former Director-General of Health; Professor at the National Institute of Health

Mr A. PINTO DE LEMOS, Attaché, Permanent Mission of Portugal to the United Nations Office and the Other International Organizations at Geneva

Adviser

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QATAR

Delegates

Mr K. M. AL MANAA, Minister of Public Health (Chief Delegate)

Dr A. A. AL BAKER, Chief, Surgical Department, Ministry of Public Health (Deputy Chief Delegate)

Dr M. A. AL HARAMI, Chief, Division of General Surgery, Ministry of Public Health

Alternates

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Dr S. A. TAJELDIN, Director, Preventive Health Services, Ministry of Public Health

Mr A. A. AL MAWLAWI, International Relations Officer, Ministry of Public Health

Mr A. S. AL ZAMAN, First Secretary, Permanent Mission of the State of Qatar to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

REPUBLIC OF KOREA

Delegates

Mr S.-C. HONG, Minister of Health and Social Affairs (Chief Delegate)

Mr N.-S. PARK, Minister, Permanent Mission of the Republic of Korea to the International Organizations at Geneva (Deputy Chief Delegate)
Dr K.-S. CHANG, Director-General, Bureau of Medical Affairs, Ministry of Health and Social Affairs

Alternates
Mr H.-H. SHIN, First Secretary, Permanent Mission of the Republic of Korea to the International Organizations at Geneva
Mr M.-G. JEON, Director, Division of International Affairs, Ministry of Health and Social Affairs
Dr W.-H. YOO, Director, Division of Tuberculosis Control, Ministry of Health and Social Affairs

ROMANIA

Delegates
Professor E. PROCA, Minister of Health (Chief Delegate)
Dr R. A. OZUN, Director of Medical Assistance, Ministry of Health (Deputy Chief Delegate)
Dr A. BULLA, Research Worker at the Institute of Phthisiology, Academy of Medical Sciences

Alternates
Dr V. TUDOR, Counsellor, Acting Chargé d'Affaires, Permanent Mission of the Socialist Republic of Romania to the United Nations Office and the Specialized Agencies at Geneva
Dr M. ZAMFIRESCU, Research Worker at the Cantacuzino Institute of Microbiology, Parasitology and Epidemiology
Mr C. IVAŞCU, Second Secretary, Permanent Mission of the Socialist Republic of Romania to the United Nations Office and the Specialized Agencies at Geneva
Mr D. IONESCU-CAZANA, Attaché, Ministry of Foreign Affairs

RWANDA

Delegates
Dr I. MUSAFILI, Minister of Public Health (Chief Delegate)
Dr J.-B. RWASINE, Director-General of Pharmacies, Ministry of Public Health[1]
Dr B. MUREMYANGANGO, Medical Director, Ndera Psychiatric Centre

[1] Chief Delegate from 13 May.

SAMOA

Delegates
Mr F. ANAPAPA, Minister of Health (Chief Delegate)
Dr SOLIA T. FAÁIUASO, Acting Director of Health, Ministry of Health

SAO TOME AND PRINCIPE

Delegates
Dr F. DA COSTA NOBRE DE CARVALHO, Physician General of the Health Services (Chief Delegate)
Dr A. SOARES MARQUES DE LIMA, Orthopaedic Physician at the Central Hospital

SAUDI ARABIA

Delegates
Dr H. A. R. GEZAIRY, Minister of Health, (Chief Delegate)
Dr H. A. AL-SUGAIR, Deputy Minister of Health (Deputy Chief Delegate)
Dr A. K. A. JAN, Technical Adviser to the Minister of Health

Alternates
Dr H. B. KIRIMLY, Director, Department of International Health, Ministry of Health
Mr A. M. AL YAMI, Chief, Pharmaceutical Division, Ministry of Health
Mr I. AL-FAWWAZ, Director of Abha Chest Diseases Hospital

SENEGAL

Delegates
Mr M. DIOP, Minister of Public Health (Chief Delegate)
Mr A. SENE, Ambassador, Permanent Representative of the Republic of Senegal to the United Nations Office and the Specialized Agencies at Geneva

Dr Moustapha TOURE, President of the Commission for Health and Social Affairs of the National Assembly

Alternates

Dr Madiou TOURE, Director of Public Health, Ministry of Public Health

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[2] Chief Delegate from 10 May.

[3] Delegate from 14 May.

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[2] Chief Delegate from 13 May.

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[1] Chief Delegate from 15 May.

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Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Belgium; Hungary; Lesotho; Nepal; Niger; Oman; Papua New Guinea; Sweden; Trinidad and Tobago; Tunisia; Upper Volta; Venezuela.

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Vice-Chairman: Dr T. DOUAMBA (Upper Volta)
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Secretary: Mr C.-H. VIGNES (Legal Adviser)

Committee on Nominations

The Committee on Nominations was composed of delegates of the following Member States: Austria; Bolivia; Botswana; Brazil; Burma; China; Czechoslovakia; Fiji; France; Guinea-Bissau; Guyana; Iran; Maldives; Qatar; Saudi Arabia; Sierra Leone; Sudan; Togo; Union of Soviet Socialist Republics; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Zaire.

Chairman: Dr T. HOUÉNASSOU-HOUANGBÉ (Togo)
Secretary: Dr H. MAHLER, Director-General

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Argentina; Brazil; Bulgaria; Fiji; India; Iran; Jamaica; Libyan Arab Jamahiriya; Nigeria; Pakistan; Swaziland; Union of Soviet Socialist Republics; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Zaire.

Chairman: Professor P. TUCHINDA (Thailand), 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: Professor R. SENAULT (France)
Vice-Chairman: Dr J. M. KASONDE (Zambia)
Rapporteur: Dr S. AZZUZ (Libyan Arab Jamahiriya)
Secretary: Mrs I. BRÜGGEMANN (Secretariat of the Headquarters Programme Committee)

Committee B

Chairman: Dr H. F. B. MARTINS (Mozambique)
Vice-Chairman: Dr M. TOTTIE (Sweden)
Rapporteur: Dr J. M. BORGOÑO (Chile)
Secretary: Dr O. W. CHRISTENSEN (Coordination with Other Organizations)

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