THIRTY-THIRD
WORLD HEALTH ASSEMBLY

GENEVA, 5-23 MAY 1980

RESOLUTIONS AND DECISIONS
ANNEXES

GENEVA
1980
ABBREVIATIONS

The following abbreviations are used in WHO documentation:

ACABQ - Advisory Committee on Administrative and Budgetary Questions
PAHO - Pan American Health Organization
PASB - Pan American Sanitary Bureau
SIDA - Swedish International Development Authority
UNCTAD - United Nations Conference on Trade and Development

ACAST - Advisory Committee on the Application of Science and Technology to Development
UNDP - United Nations Development Programme
CIDA - Canadian International Development Agency
UNRO - Office of the United Nations Disaster Relief Coordinator
CIOMS - Council for International Organizations of Medical Sciences
UNEP - United Nations Environment Programme
DANIDA - Danish International Development Agency
UNESCO - United Nations Educational, Scientific and Cultural Organization
ECA - Economic Commission for Africa
UNFDAC - United Nations Fund for Drug Abuse Control
ECE - Economic Commission for Europe
UNFPA - United Nations Fund for Population Activities
ECLA - Economic Commission for Latin America
UNHCR - Office of the United Nations High Commissioner for Refugees
ECWA - Economic Commission for Western Asia
UNICEF - United Nations Children's Fund
ESCAP - Economic and Social Commission for Asia and the Pacific
UNIDO - United Nations Industrial Development Organization
FAO - Food and Agriculture Organization of the United Nations
UNITAR - United Nations Institute for Training and Research
IAEA - International Atomic Energy Agency
UNRWA - United Nations Relief and Works Agency for Palestine Refugees in the Near East
IARC - International Agency for Research on Cancer
UNSCERAR - United Nations Scientific Committee on the Effects of Atomic Radiation
IBRD - International Bank for Reconstruction and Development
USAID - United States Agency for International Development
ICAO - International Civil Aviation Organization
WFP - World Food Programme
IFAD - International Fund for Agricultural Development
WHO - World Health Organization
ILO - International Labour Organization (Office)
WIPO - World Intellectual Property Organization
IMCO - Inter-Governmental Maritime Consultative Organization
WMO - World Meteorological Organization
ITU - International Telecommunication Union

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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PREFACE

The Thirty-third World Health Assembly was held at the Palais des Nations, Geneva, from 5 to 23 May 1980, in accordance with the decision of the Executive Board at its sixty-fourth session. Its proceedings are published in three volumes, containing, in addition to other relevant material:

- Resolutions and decisions, and list of participants - document WHA33/1980/REC/1
- Verbatim records of plenary meetings, and committee reports - document WHA33/1980/REC/2
- Summary records of committees - document WHA33/1980/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

WHA33.1  Admission of a new Member: San Marino

The Thirty-third World Health Assembly

ADmits San Marino as a Member of the World Health Organization, subject to the deposit of a formal instrument with the Secretary-General of the United Nations in accordance with Article 79 of the Constitution.


WHA33.2  Admission of a new Member: Zimbabwe

The Thirty-third World Health Assembly

ADmits Zimbabwe as a Member of the World Health Organization, subject to the deposit of a formal instrument with the Secretary-General of the United Nations in accordance with Article 79 of the Constitution.


WHA33.3  Declaration of global eradication of smallpox

The Thirty-third World Health Assembly, on this the eighth day of May 1980;

Having considered the development and results of the global programme on smallpox eradication initiated by WHO in 1958 and intensified since 1967;

1. DECLARES SOLEMNLY THAT THE WORLD AND ALL ITS PEOPLES HAVE WON FREEDOM FROM SMALLPOX, WHICH WAS A MOST DEVASTATING DISEASE SLEEPING IN EPIDEMIC FORM THROUGH MANY COUNTRIES SINCE EARLIEST TIMES, LEAVING DEATH, BLINDNESS AND DISFIGUREMENT IN ITS WAKE, AND WHICH ONLY A DECADE AGO WAS RAMPANT IN AFRICA, ASIA AND SOUTH AMERICA;

2. EXPRESS ITS DEEP GRATITUDE TO ALL NATIONS AND INDIVIDUALS WHO CONTRIBUTED TO THE SUCCESS OF THIS NOBLE AND HISTORIC ENDEAVOUR;

3. CALLS THIS UNPRECEDENTED ACHIEVEMENT IN THE HISTORY OF PUBLIC HEALTH TO THE ATTENTION OF ALL NATIONS, WHICH BY THEIR COLLECTIVE ACTION HAVE FREED MANKIND OF THIS ANCIENT SCOURGE AND, IN SO DOING, HAVE DEMONSTRATED HOW NATIONS WORKING TOGETHER IN A COMMON CAUSE MAY FURTHER HUMAN PROGRESS.

Hbk Res., Vol. II (3rd ed.), 1.10.4 (Eighth plenary meeting, 8 May 1980)
Global smallpox eradication

The Thirty-third World Health Assembly,

Having reviewed the report of the Global Commission for the Certification of Smallpox Eradication prepared in December 1979;

Mindful that smallpox was a most devastating disease, sweeping in epidemic form through many countries since earliest times, and leaving death, blindness and disfigurement in its wake; that, despite the existence of a vaccine since the beginning of the last century, the disease had persisted in many parts of the world; and that only a decade ago the disease was rampant in Africa, Asia and South America;

Affirming that the commitment of the Health Assembly to the worldwide eradication of smallpox, first initiated, in accordance with resolution WHA11.54, in 1958, and intensified, in accordance with resolution WHA20.15, in 1967, has now been met;

Expressing appreciation of the efforts made by all nations to achieve global smallpox eradication, either through their national programmes or through the assistance which they provided, with the wholehearted support of multilateral, bilateral and voluntary agencies and with the constant encouragement of the world's news media;

1. ENDORSES the conclusions of the Global Commission that smallpox eradication has been achieved throughout the world, as proclaimed in resolution WHA33.3, and that there is no evidence that smallpox will return as an endemic disease;

2. FURTHER ENDORSES the recommendations of the Global Commission on the policy for the post-eradication era, annexed to this resolution;

3. REQUESTS Member States to cooperate fully in the implementation of the Commission's recommendations;

4. URGES, in particular, the immediate implementation of the recommendations on the discontinuation of smallpox vaccination except for investigators at special risk and the termination of the requirement for international certificates of vaccination against smallpox in Member States which have not already taken this measure; the continued epidemiological surveillance of suspected smallpox cases; the monitoring of safety measures in laboratories retaining variola virus and further reduction in the number of such laboratories; and the promotion of research on orthopoxviruses;

5. REQUESTS the Director-General to ensure the production, within a reasonable period of time, of appropriate publications describing smallpox and its eradication, in order to preserve the unique historical experience of eradication and thereby contribute to the development of other health programmes;

6. INVITES all Member States, as well as multilateral, bilateral and voluntary agencies, to ensure that the cooperation and support which has brought about the global eradication of smallpox is continued in other fields, and to invest the resources saved as a result of smallpox eradication in other priority health programmes, so as to maintain the struggle towards better health for all mankind;

7. CALLS ON the Director-General to promote and coordinate the implementation of the Global Commission's recommendations on policy for the post-eradication era, so that the world may remain permanently free of this disease, and to report on this matter to future Health Assemblies as necessary.
Annex

Recommendations of the Global Commission for the Certification of Smallpox Eradication regarding Policy for the Post-Eradication Era

Vaccination policy

Recommendation 1. Smallpox vaccination should be discontinued in every country except for investigators at special risk.

Recommendation 2. An international certificate of vaccination against smallpox should no longer be required of any traveller.

Reserve stocks of vaccine

Recommendation 3. Sufficient freeze-dried smallpox vaccine to vaccinate 200 million people should be maintained by WHO in refrigerated depots in two countries, together with stocks of bifurcated needles.

Recommendation 4. The stored vaccine should be periodically tested for potency.

Recommendation 5. Seed lots of vaccinia virus suitable for the preparation of smallpox vaccine should be maintained in designated WHO collaborating centres.

Recommendation 6. National health authorities that have vaccine stocks should be asked to inform WHO of the amount of vaccine maintained.

Investigation of suspected smallpox cases

Recommendation 7. In order to maintain public confidence in the fact of global eradication, it is important that rumours of suspected smallpox, which can be expected to occur in many countries, should be thoroughly investigated. Information should be provided to WHO, if requested, so that it can be made available to the world community.

Recommendation 8. WHO should maintain an effective system to coordinate and participate in the investigation of suspected smallpox cases throughout the world. The international smallpox-rumour register should be maintained.

Laboratories retaining variola virus stocks

Recommendation 9. No more than four WHO collaborating centres should be approved as suitable to hold, and handle, stocks of variola virus. A collaborating centre would be approved only if it had adequate containment facilities. Each such centre should provide WHO annually with relevant information on its safety measures and should be inspected periodically by WHO.

Recommendation 10. Other laboratories should be asked to destroy any stocks of variola virus that they hold, or transfer them to an approved WHO collaborating centre.

Human monkeypox

Recommendation 11. In collaboration with country health services WHO should organize and assist a special surveillance programme on human monkeypox, its epidemiology, and its ecology in areas where it is known to have occurred. The programme should continue until 1985, when a further assessment of the situation should be made.

Laboratory investigations

Recommendation 12. WHO should continue to encourage and coordinate research on orthopoxviruses.
Recommendation 13. WHO should maintain the system of WHO collaborating centres for carrying out diagnostic work and research on orthopoxviruses.

Recommendation 14. Research workers who do not work in a WHO collaborating centre and who wish to carry out experiments with variola or whitepox virus that are approved by the appropriate WHO committee should be offered the use of the special facilities in a WHO collaborating centre.

Recommendation 15. Research on poxviruses other than variola or whitepox viruses should not be performed under circumstances where there is any possibility of cross-contamination with these two agents.

Documentation of the smallpox eradication programme

Recommendation 16. WHO should ensure that appropriate publications are produced describing smallpox and its eradication and the principles and methods that are applicable to other programmes.

Recommendation 17. All relevant scientific, operational and administrative data should be catalogued and retained for archival purposes in WHO headquarters and perhaps also in several centres interested in the history of medicine.

WHO headquarters staff

Recommendation 18. An interregional team consisting of not less than two epidemiologists with past experience in the smallpox eradication campaign, plus supporting staff, should be maintained at WHO headquarters until at least the end of 1985. At least one additional field officer should be assigned to cover areas where human monkeypox is under investigation.

Recommendation 19. WHO should set up a committee on orthopoxvirus infections.


WHA33.5 Financial report on the accounts of WHO for 1979, and report of the External Auditor

The Thirty-third World Health Assembly,

Having examined the financial report of the Director-General for the period 1 January to 31 December 1979 and the report of the External Auditor for the same financial period;¹

Having noted the report of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-third World Health Assembly;²

ACCEPTS the Director-General's financial report and the report of the External Auditor for the financial year 1979.

Hbk Res., Vol. II (3rd ed.), 7.1.11 (Fourteenth plenary meeting, 16 May 1980 - Committee B, first report)

¹ Document A33/17.
² Document A33/37.
WHA33.6 Status of collection of annual contributions and of advances to the Working Capital Fund

The Thirty-third World Health Assembly

1. NOTES the status, as at 13 May 1980, of the collection of annual contributions and of advances to the Working Capital Fund, as reported by the Director-General;¹

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 1980;

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 (Fourteenth plenary meeting, 16 May 1980 - Committee B, first report)

WHA33.7 Members in arrears in the payment of their contributions to an extent which may invoke the provisions of Article 7 of the Constitution

The Thirty-third World Health Assembly,

Having considered the report² of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-third 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 the Central African Republic, Chad, the Dominican Republic and Grenada 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 communication received from the Dominican Republic with respect to the settlement of its arrears;

1. DECIDES:

(1) not to suspend the voting privileges of the Central African Republic, Chad, the Dominican Republic and Grenada at the Thirty-third World Health Assembly;

(2) to accept the proposal of the Dominican Republic for the settlement of its arrears and to cancel the arrangements for such settlement previously accepted by the Health Assembly in resolution WHA25.6;

(3) to apply the payment of US $65 295 received in May 1980 from the Dominican Republic first to the additional advance to the Working Capital Fund, then to the 1979 contribution, notwithstanding the provisions of Financial Regulation 5.8, and the balance to the consolidated arrears;

¹ Document A33/32.
² Document A33/38.
(4) to agree to the liquidation of the balance of the consolidated arrears of the Dominican Republic in nine equal annual instalments of US $25,683 beginning in 1980 and a final instalment of US $25,682, subject to the provisions of Financial Regulation 5.6;

(5) that, if the arrangements specified above are fulfilled by the Dominican Republic, it will be unnecessary for future Assemblies to invoke the provisions of paragraph 2 of resolution WHA8.13 and that, notwithstanding the provisions of Financial Regulation 5.8, payments of contributions of the Dominican Republic for the financial period 1980-1981 and future financial periods shall be credited to the financial period concerned;

2. URGES the Members concerned to regularize their position;

3. CONSIDERS that, should the position of these four Members still be unsatisfactory as concerns arrears and the possible application of Article 7 of the Constitution at the time the Thirty-fourth World Health Assembly meets, that Assembly should consider suspending the voting privileges of these Members;

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

Hbk Res., Vol. II (3rd ed.), 7.1.2.4 (Fourteenth plenary meeting, 16 May 1980 - Committee B, first report)

WHAS.8 Financial reports and extrabudgetary resources

The Thirty-third World Health Assembly,

Having considered the report of the Director-General on financial reports and extrabudgetary resources;

Having considered the amendments to the Financial Regulations proposed by the Director-General;

Having noted the Director-General's proposals to include in the annual financial reports to the Health Assembly information on income and expenditure relating to all extrabudgetary funds available for programme purposes;

1. ADOPTS the amendments to the Financial Regulations as appended to the Director-General's report;

2. APPROVES the proposals of the Director-General to report annually to the Health Assembly on all extrabudgetary resources available for programme purposes;

3. DECIDES that this resolution supersedes resolution WHA26.24.

Hbk Res., Vol. II (3rd ed.), 7.1.11; 7.1.1; 7.1.9 (Fourteenth plenary meeting, 16 May 1980 - Committee B, first report)

WHA33.9  Assessment of the Seychelles

The Thirty-third World Health Assembly,

Noting that the Seychelles, a Member of the United Nations, became a Member of the World Health Organization by depositing with the Secretary-General of the United Nations a formal instrument of acceptance of the WHO Constitution on 11 September 1979;

Noting that the United Nations General Assembly, in resolutions 32/39 and 34/6, established the assessment of the Seychelles at the rate of 0.01% for the years 1978 to 1982;

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

DECIDES:

(1) that the Seychelles shall be assessed at the rate of 0.01% for 1979 and future financial periods;

(2) that the assessment for 1979 shall be reduced to one-ninth of 0.01%.

Hbk Res., Vol. II (3rd ed.), 7.1.2.2  (Fourteenth plenary meeting, 16 May 1980 - Committee B, first report)

WHA33.10  Assessment of Equatorial Guinea

The Thirty-third World Health Assembly,

Noting that Equatorial Guinea, a Member of the United Nations, became a Member of the World Health Organization by depositing with the Secretary-General of the United Nations a formal instrument of acceptance of the WHO Constitution on 5 May 1980;

Noting that the United Nations General Assembly, in resolution 34/6, established the assessment of Equatorial Guinea at the rate of 0.01% for the years 1980 to 1982;

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

DECIDES:

(1) that Equatorial Guinea shall be assessed at the rate of 0.01% for 1980-1981 and future financial periods;

(2) that the assessment for 1980 shall be reduced to one-third of 0.01%.

Hbk Res., Vol. II (3rd ed.), 7.1.2.2  (Fourteenth plenary meeting, 16 May 1980 - Committee B, first report)
WHA33.11 Assessment of San Marino

The Thirty-third World Health Assembly,

Noting the admission of San Marino to membership in the Organization on 6 May 1980;

Noting that the United Nations General Assembly, in resolution 34/6, established the assessment of San Marino at the rate of 0.01% for the years 1980 to 1982;

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

DECIDES:

(1) that San Marino shall be assessed at the rate of 0.01% for 1980-1981 and future financial periods;

(2) that the assessment for 1980 shall be reduced to one-third of 0.01%.

WHA33.12 Unpaid contributions of Southern Rhodesia

The Thirty-third World Health Assembly,

Having considered the report of the Director-General on the unpaid contributions of Southern Rhodesia relating to the period 1967 to 1981;

Recalling that associate membership of Southern Rhodesia had been suspended since 1965;

Considering that the unpaid contributions of Southern Rhodesia for the period 1967 to 1979 form part of the non-cash portion of the Assembly Suspense Account and that the unpaid contribution for the current financial period 1980-1981 is to be included therein at the end of the financial period;

1. DECIDES that the paid-up advance of Southern Rhodesia to the Working Capital Fund, amounting to US $510, shall be transferred in the Organization's books in favour of Zimbabwe;

2. AUTHORIZES the Director-General to adjust the accounts of the Organization by cancelling the contributions recorded as being due by Southern Rhodesia for the period 1967 to 1981, amounting to US $238,020.

1 See Annex 1.
WHA33.13 Assessment of Zimbabwe

The Thirty-third World Health Assembly,

Noting that Zimbabwe was admitted to membership in the Organization on 6 May 1980;

Recalling that the Twenty-second World Health Assembly in resolution WHA22.6 decided that from 1968 new Members shall be assessed in accordance with the practice followed by the United Nations in assessing new Members for their year of admission;

DECIDES:

(1) that Zimbabwe shall be assessed for 1980-1981 and future financial periods at a rate to be fixed by the Health Assembly as and when an assessment rate for this country has been established by the United Nations Committee on Contributions;

(2) that Zimbabwe shall be assessed at the provisional rate of 0.01% for 1980-1981 and future financial periods, to be adjusted to the definitive assessment rate when established by the Health Assembly;

(3) that the assessment to be applied to 1980 shall be reduced to one-third of 0.01%.

Hbk Res., Vol. II (3rd ed.), 7.1.2.2 (Fourteenth plenary meeting, 16 May 1980 - Committee B, first report)

WHA33.14 Amendment to the scale of assessments to be applied to the second year of the financial period 1980-1981

The Thirty-third World Health Assembly,

Noting that the United Nations General Assembly, in resolution 34/6, adopted the scale of assessments for the contributions of Member States to the United Nations budget for the financial years 1980, 1981 and 1982 and established the rates at which States which are not Members of the United Nations but which participate in certain of its activities shall be called upon to contribute towards the 1980, 1981 and 1982 expense of such activities;

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

Recalling further that the Twenty-sixth World Health Assembly, in resolution WHA26.21, expressed the opinion that the scale of assessments in WHO should follow as closely as possible that of the United Nations, and confirmed the principles laid down in resolutions WHA8.5 and WHA24.12 for the establishment of the scale of assessments of WHO;

Noting that by resolution WHA32.8 the Thirty-second World Health Assembly adopted a scale of assessments for 1980-1981;

Noting also that Financial Regulation 5.3 provides that in the first year of the financial period the Health Assembly may decide to amend the scale of assessments to be applied to the second year of the financial period;

Taking into account the accession to membership of Equatorial Guinea, San Marino, Seychelles and Zimbabwe;

Noting that the assessment of Southern Rhodesia has been deleted from the Undistributed Reserve;
1. DECIDES to amend the scale of assessments to be applied to 1981, subject to the provisions of paragraph 2, to be as follows:

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<tr>
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<td>Member</td>
<td>Assessment (percentage)</td>
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<td>0.02</td>
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<td>Zimbabwe</td>
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</table>

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;

3. DECIDES to amend the Appropriation Resolution for the financial period 1980-1981 (resolution WHA32.28) as follows:

   (1) in paragraph A, decrease appropriation section 10 (Undistributed Reserve) by US $243 100;

   (2) decrease the total shown in the same paragraph by US $243 100;

   (3) decrease the amount under paragraph D, relating to assessments on Members, by US $243 100.
WH33.15 Real Estate Fund

The Thirty-third World Health Assembly,

Having considered resolution EB65.R15 and the report of the Director-General on the status of projects financed from the Real Estate Fund and the estimated requirements of the Fund for the period 1 June 1980 to 31 May 1981;¹

Recognizing that certain estimates in that report must necessarily remain provisional because of the continuing fluctuation in exchange rates;

Noting in particular that it is now necessary to undertake a further extension to the building of the Regional Office for the Western Pacific;

1. AUTHORIZES the financing from the Real Estate Fund of the projects envisaged in the Director-General’s report at the following estimated costs:

<table>
<thead>
<tr>
<th>Project Description</th>
<th>Cost</th>
</tr>
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<tbody>
<tr>
<td>Extension of the Regional Office for the Western Pacific</td>
<td>US$1,367,000</td>
</tr>
<tr>
<td>Demolition of part of building &quot;V&quot; at headquarters and construction of a new outer wall</td>
<td>US$115,000</td>
</tr>
<tr>
<td>Construction of an additional car parking area at headquarters</td>
<td>US$85,000</td>
</tr>
</tbody>
</table>

2. APPROPRIATES to the Real Estate Fund, from casual income, the sum of US $1,290,000.

Hbk Res., Vol. II (3rd ed.), 7.1.7 (Fourteenth plenary meeting, 16 May 1980 - Committee B, first report)

WH33.16 Transfer of the Regional Office for the Eastern Mediterranean²

The Thirty-third World Health Assembly,

Having regard to proposals which have been made to remove from Alexandria the WHO Regional Office for the Eastern Mediterranean;

Taking note of the differing views which have been expressed in the Health Assembly on the question of whether the World Health Organization may transfer the Regional Office without regard to the provisions of Section 37 of the Agreement between the World Health Organization and Egypt of 25 March 1951;

Noting further that the Working Group of the Executive Board has been unable to make a judgement or a recommendation on the applicability of Section 37 of this Agreement;

DECIDES, prior to taking any decision on removal of the Regional Office, and pursuant to Article 76 of the Constitution of the World Health Organization and Article X of the Agreement between the United Nations and the World Health Organization approved by the General Assembly of the United Nations on 15 November 1947, to submit to the International Court of Justice for its Advisory Opinion the following questions:

² See Annex 2.
(1) Are the negotiation and notice provisions of Section 37 of the Agreement of 25 March 1951 between the World Health Organization and Egypt applicable in the event that either party to the Agreement wishes to have the Regional Office transferred from the territory of Egypt?

(2) If so, what would be the legal responsibilities of both the World Health Organization and Egypt, with regard to the Regional Office in Alexandria, during the two-year period between notice and termination of the Agreement?

Hbk Res., Vol. II (3rd ed.), 5.2.5

(Fifteenth plenary meeting, 20 May 1980 - Committee B, second report)

WHA33.17 Study of WHO's structures in the light of its functions

The Thirty-third World Health Assembly,

Recalling that the main social target of governments and WHO in the coming decades is the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life;

Guided by the Declaration and recommendations of the International Conference on Primary Health Care held in Alma-Ata, and by resolution WHA32.30 concerning the formulation of strategies for health for all by the year 2000;

Noting with satisfaction the United Nations General Assembly resolution 34/58 on health as an integral part of development, which reinforces the responsibilities entrusted to WHO in connexion with the attainment of health for all by the year 2000;

Recalling that, in accordance with its Constitution WHO is an organization of Member States cooperating among themselves and with others to promote the health of all people, and that this cooperative action embodies the truly international nature of the Organization;

Mindful of WHO's constitutional functions of acting as the directing and coordinating authority on international health work and of entering into technical cooperation with its Member States and facilitating technical cooperation among them;

Convinced that through its international health work the Organization can be a powerful instrument in helping to reduce international tension, to overcome racial and social discrimination, and to promote peace;

Realizing that, in consequence of the above, unprecedented efforts will be required in the health and related socioeconomic sectors throughout the world;

1. DECIDES:

(1) to concentrate the Organization's activities over the coming decades, as far as is possible in the light of all its constitutional obligations, on support to national, regional and global strategies for attaining health for all by the year 2000;

(2) to focus the Organization's cooperative activities within the United Nations system on joint efforts to support health as part of development, to devise the New International Development Strategy and to establish the New International Economic Order;

(3) to strengthen the roles of the Organization in promoting action for health in addition to indicating how such action might be carried out, and in developing health

1 See Annex 3,
2. **URGES** Member States, in the spirit of the policies, principles and programmes they have adopted collectively in WHO:

   (1) to review the role of their ministries of health, strengthening them as necessary so that they can fully assume the function of directing and coordinating authority on national health work, and to establish or strengthen multisectoral national health councils;

   (2) to mobilize all possible resources in their countries that can contribute to health development, including those of other relevant sectors and nongovernmental organizations;

   (3) to tighten their coordinating mechanisms so as to ensure the mutual relevance and support of their own health development strategy on the one hand and their technical cooperation with WHO and with other Member States of WHO on the other;

   (4) to ensure that WHO's action in their countries reflects adequately resolution WHA31.27 concerning the conclusions and recommendations of the Executive Board's organizational study on "WHO's role at the country level, particularly the role of the WHO representatives", and in particular the shift from technical assistance to technical cooperation;

   (5) to consider the possibility of increasing the use of their Organization as an effective agent to facilitate cooperation among them;

   (6) to establish or strengthen mechanisms for ensuring continuing dialogue and cooperation with their Organization with a view to making sure that national and international health programmes are well coordinated;

   (7) to coordinate their representation at regional committees and the Health Assembly, and to designate representatives to the regional committees and delegates to the Health Assembly who will later be in a position to influence national health policy so as to make it consistent with collective health policy adopted in WHO;
(8) to take into account as far as possible the multidisciplinary nature of health activities when establishing their delegations to the Health Assembly and the regional committees;

(9) to bring their national health policies to the attention of the regional committees;

(10) to coordinate their representation in WHO and in the United Nations and the specialized agencies on all matters relating to health, and particularly the role of health in development;

3. URGES the regional committees:

(1) to take a more active part in the work of the Organization and to submit to the Executive Board their recommendations and concrete proposals on matters of regional and global interest;

(2) to intensify their efforts to develop regional health policies and programmes in support of national, regional and global strategies for health for all, and to consider establishing or strengthening appropriate subcommittees to this end;

(3) to promote greater interaction in the regions between the activities of WHO and those of all other bodies concerned, including bodies of the United Nations system and nongovernmental organizations, in order to stimulate common efforts for attaining health for all by the year 2000;

(4) to support technical cooperation among all Member States, particularly for attaining health for all;

(5) to provide support for the establishment or strengthening of multisectoral national health councils to Member States which so desire;

(6) to foster the channelling of external funds for health into priority activities in the strategies for health for all of the countries most in need;

(7) to extend and deepen their analysis of the interregional, regional and national implications of Health Assembly and Executive Board resolutions, and to provide such analyses to Member States;

(8) to increase their monitoring, control and evaluation functions so as to ensure the proper reflection of national, regional and global health policies in regional programmes and the proper implementation of these programmes, and to include in their programmes of work the review of WHO's action in individual Member States within the regions;

4. REQUESTS the Executive Board:

(1) to strengthen its role in giving effect to the decisions and policies of the Health Assembly and in providing advice to it, particularly with respect to ways of attaining health for all by the year 2000, among other things by ensuring that the Organization's general programmes of work, medium-term programmes, and programme budgets are optimally oriented towards supporting the strategies for health for all of Member States;

(2) to become increasingly active in presenting major issues to the Health Assembly and in responding to the comments of delegates;

(3) to foster the correlation of its work with that of the regional committees and the Health Assembly, among other things by reviewing carefully and drawing conclusions from the policy proposals of the regional committees in matters of worldwide interest, particularly in preparation for the ensuing Health Assembly;
(4) to monitor on behalf of the Health Assembly the way the regional committees reflect the Assembly's policies in their work, and the manner in which the Secretariat provides support to Member States individually, as well as collectively in the regional committees, Executive Board and Health Assembly;

(5) to review regularly measures taken by the relevant bodies of the United Nations system in the areas of health and development, and to ensure the coordination of WHO's activities with the activities of those bodies in order to promote an inter-sectoral approach to health development, thus facilitating the attainment of the goal of health for all by the year 2000;

5. REQUESTS the Director-General and Regional Directors to act on behalf of the collectivity of Member States in responding favourably to government requests only if these are in conformity with the Organization's policies;

6. REQUESTS the Director-General:

(1) to continue to exercise to the full all the powers entrusted to him by the Constitution in his capacity as chief technical and administrative officer of the Organization, subject to the authority of the Executive Board and the Health Assembly;

(2) to ensure the provision of timely, adequate and consistent Secretariat support to the Organization's Member States, individually and collectively, and to this end to take all the measures within his constitutional prerogatives that he considers necessary;

(3) to expand the engagement of national staff of the country concerned in the execution of collaborative projects, to review the engagement of international WHO field staff, and to take any measures required so that such WHO staff become fully involved with the collaborative national programmes;

(4) to redefine the functions of the regional offices and of headquarters in such a way as to ensure that they provide adequate and consistent support to Member States in their cooperation with WHO and among themselves, and to adapt accordingly the organizational structures and staffing of the regional offices and of headquarters, reporting to the regional committees, the Executive Board and the Health Assembly as appropriate on his projects and plans in conformity with the constitutional functions of these bodies;

(5) to monitor the implementation of the decisions in this resolution and to keep the regional committees, the Executive Board and the Health Assembly fully informed on progress.

Hbk Res., Vol. II (3rd ed.), 4.2.7 (Sixteenth plenary meeting, 21 May 1980)

WH33.18 Health conditions of the Arab population in the occupied Arab territories, including Palestine

The Thirty-third World Health Assembly,

Mindful of the basic principle laid down in the WHO Constitution which provides that the health of all peoples is fundamental to the attainment of peace and security;

Aware of its responsibility for ensuring proper health conditions for all peoples who suffer from exceptional situations, including foreign occupation and especially settler colonialism;
Bearing in mind that the WHO Constitution provides that "health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity";

Affirming the principle that the acquisition of territories by force gravely affects the health, psychological, mental and physical conditions of the population under occupation, and that this can only be rectified by the complete and immediate termination of the occupation;

Considering that the States parties to the Geneva Convention of 12 August 1949 pledged, under Article One thereof, not only to respect the Convention but also to ensure its respect in all circumstances;

Recalling the United Nations resolutions concerning the inalienable right of the Palestinian people to self-determination;

Affirming the right of Arab refugees and displaced persons to return to their homes and properties from which they were forced to emigrate;

Recalling all the previous WHO resolutions on this matter, especially resolution WHA26.56, dated 23 May 1973, and subsequent resolutions;

Recalling resolution 1, A and B (XXXVI), 1980, adopted by the Commission on Human Rights, which condemns Israel's violations of human rights in occupied Arab territories, including Palestine;

Taking note of the report of the Special Committee of Experts;

I

1. NOTES the report of the Director-General on health assistance to refugees, displaced persons and the Arab population in the occupied territories, including Palestine;

2. EXPRESSES its appreciation of the Director-General's efforts and requests that he continue his collaboration with the Palestine Liberation Organization in providing all necessary assistance to the Palestinian people;

II

Having examined the annual report of the United Nations Relief and Works Agency for Palestine Refugees in the Near East;

Deeply concerned by the deterioration of the situation suffered by the Agency concerning its budget and the services provided, due to the repeated Israeli aggression;

1. THANKS the United Nations Relief and Works Agency for Palestine Refugees in the Near East for its unfailing efforts;

2. REQUESTS the Director-General to continue his collaboration with the United Nations Relief and Works Agency for Palestine Refugees in the Near East by all possible means, inasmuch as to ease the difficulties it is facing and increase the services it provides to the Palestinian people;

III

1. EXPRESSES its deep concern at the poor health and psychological conditions suffered by the inhabitants of the occupied Arab territories, including Palestine;

2. CONDEMNS all acts undertaken by Israel to change the physical aspects, the geography, the institutional and legal status or context of the occupied Arab territories, including Palestine, and considers Israel's policy in settling part of its population and new settlers in the occupied territories a flagrant violation of the Geneva Convention Relative to the Protection of Civilian Persons in Time of War and the relevant United Nations resolutions;
3. DECLARES that the establishment of Israeli settlements in the occupied Arab territories, including Palestine, and the illicit exploitation of natural wealth and resources of the Arab inhabitants in those territories, especially the confiscation of Arab water sources and their diversion for the purposes of occupation and settlement, inflict serious damage on the health of the inhabitants;

4. CONDEMNS the inhuman practices to which Arab prisoners and detainees are subject in Israeli prisons, resulting in the deterioration of their health, psychological and mental conditions;

5. CONDEMNS Israel for its refusal to implement Health Assembly resolutions calling upon it to allow refugees and displaced persons to return to their homes;

6. CONDEMNS Israel for its refusal to apply the Fourth Geneva Convention Relative to the Protection of Civilian Persons in Time of War, of 12 August 1949;

7. CONDEMNS Israel for its arbitrary practices and its continuous shelling of Palestine refugee housing settlements in southern Lebanon which affects the physical, social and psychological health conditions of the Arab inhabitants, and considers that its refusal to implement resolutions of the World Health Organization constitutes an explicit breach of the letter and spirit of the WHO Constitution;

8. ENDORSES the opinion of the Special Committee of Experts that it is "fruitless to imagine that a state of complete physical, mental and social welfare can be achieved" under occupation;

9. REQUESTS the Special Committee to continue its task with respect to all the implications of occupation and the policies of the occupying Israeli authorities and their various practices which adversely affect the health conditions of the Arab inhabitants in the occupied Arab territories and Palestine, and to submit a report to the Thirty-fourth World Health Assembly, bearing in mind all the provisions of this resolution, in coordination with the Arab States concerned and the Palestine Liberation Organization.


WHA33.19 Periodicity of Health Assemblies

The Thirty-third World Health Assembly,

Having considered the Director-General's report on the study of WHO's structures in the light of its functions, prepared in response to resolution WHA31.27, and in particular the Director-General's report on the periodicity of Health Assemblies, and resolution EB65.R12;

Having also considered the Executive Board's review of the periodicity of Health Assemblies, in response to resolution WHA32.26;

Having in mind the need to preserve and strengthen the influence of the Member States in the Organization;

Recognizing that the principle of biennial programming and budgeting has been implemented in WHO;

1 See Annex 3 and document EB65/1980/REC/1, Annexes 8, 9 and 10.
Understanding that a change from annual to biennial Health Assemblies would necessitate changing the text of Articles 13, 14, 15 and 16 of the Constitution as set out in the Director-General's report;¹

Considering that action by the Health Assembly to amend the Constitution under Article 73 is not possible until the Members have had at least six months in advance of the Health Assembly to consider the text of any proposed amendment to the Constitution;

Appreciating that many advantages could be obtained by shortening the Health Assemblies in alternate years;

1. REQUESTS the Director-General, within the provisions of Article 73 of the Constitution, to transmit this resolution, as well as the text of the proposed constitutional amendments, to Member States for their consideration;

2. URGES Member States to give careful attention over the coming year to the necessary constitutional changes as set out in the Director-General's report;¹

3. REQUESTS the regional committees to consider the implications for their work of biennial Health Assemblies and report these to the Executive Board at its sixty-seventh session;

4. REQUESTS the Executive Board to examine the consequences of the introduction of biennial Health Assemblies for the work and functioning of all bodies of the Organization, in particular the Executive Board and the regional committees, with the aim of strengthening these, and to make appropriate recommendations to the Thirty-fourth World Health Assembly;

5. RECOMMENDS that the Thirty-fourth World Health Assembly in 1981, under Articles 73 and 60 of the Constitution, and on the basis of recommendations and conclusions of the Executive Board, consider amending the texts of Articles 13, 14, 15 and 16 of the Constitution in order to permit the change from annual to biennial Health Assemblies, and at the same time consider taking other decisions relating to WHO's structure;

6. BELIEVES that, as soon as possible, in the meantime Health Assemblies in the even years (when there is not a full programme budget to consider) should be limited to not more than two weeks' duration.

Hbk Res., Vol. II (3rd ed.), 4.1.1.3 (Seventeenth plenary meeting, 23 May 1980 - Committee B, fourth report)

WHA33.20 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 Thirty-third World Health Assembly,

Having considered 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;²

Recalling resolutions EB59.R34 and WHA30.17;

Believing that the organizational study provides a constructive basis for the future use of experts and institutions in support of WHO's work;

Believing further that the study positively contributes to the review of WHO's structures in the light of its functions and will have important implications for the formulation and implementation of national, regional and global strategies for health for all by the year 2000;

1. **CONGRATULATES** the Executive Board on its 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;

2. **NOTES** with appreciation and concurs with its findings, conclusions and recommendations, especially with regard to

   (1) the broader definition of the WHO expert and the enlarged conception of the role of the WHO collaborating centre;

   (2) the wider selection of experts and institutions being called upon to cooperate with the Organization to ensure an adequate scientific, technical and international balance of the WHO system of expertise as a whole; and

   (3) the major role devolving upon the WHO regions in the building up and operation of the system through the active collaboration of the Member countries themselves;

3. **URGES** Member States to give every possible support to the Organization in the development of its expert resources, by making available to it national health staff and institutions able to contribute to its activities;

4. **REQUESTS** the Director-General to take the action required to give effect to the conclusions and recommendations of the study, especially concerning:

   (1) the drawing up of new regulations, to be adopted by the Health Assembly, to govern WHO's mechanisms of expert consultation and institutional collaboration as a whole;

   (2) the formulation of a plan of action to adjust the system as now envisaged to the needs of WHO's programme and in particular to programme priorities as determined under the Sixth General Programme of Work, and to the medium- and long-term development of biomedical and health services research;

5. **FURTHER REQUESTS** the Director-General to report to the Executive Board and to the Health Assembly, as appropriate, on the progress made in following up on the organizational study.

Hbk Res., Vol. II (3rd ed.), 4.2.7

(Seventeenth plenary meeting, 23 May 1980 - Committee B, fourth report)

WHA33.21 Agreement between WHO and the International Fund for Agricultural Development

The Thirty-third World Health Assembly,

Having considered the Director-General's report on an Agreement between the World Health Organization and the International Fund for Agricultural Development;¹

Taking into consideration Article 70 of the Constitution of the World Health Organization;

1. **APPROVES** the Agreement between the World Health Organization and the International Fund for Agricultural Development;

¹ Document A33/23.
2. AUTHORIZES the Director-General to sign this Agreement on behalf of the World Health Organization together with the President of the International Fund for Agricultural Development.

WHA33.22 Health assistance to refugees and displaced persons in Cyprus

The Thirty-third World Health Assembly,

Mindful of the principle that the health of all peoples is fundamental to the attainment of peace and security;

Recalling resolutions WHA28.47, WHA29.44, WHA30.26, WHA31.25 and WHA32.18;

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-fourth World Health Assembly on such assistance.

WHA33.23 Health and medical assistance to Lebanon

The Thirty-third World Health Assembly,

Mindful of the principle that the health of all peoples is a basic condition for peace and security;

Having examined the Director-General's report on health and medical assistance to Lebanon during the period April 1979 - March 1980;

Recalling previous resolutions WHA29.40, WHA30.27, WHA31.26 and WHA32.19 on health and medical assistance to Lebanon;

Taking note of all relevant United Nations resolutions concerning Lebanon;

1 Document A33/25.
Taking into consideration the appeals made by the Secretary-General of the United Nations for international assistance for the reconstruction and development of Lebanon;

Considering that the magnitude of the persisting health problems in Lebanon necessitates the continuation and intensification of the health and medical assistance to Lebanon;

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 appreciation to all the specialized agencies of the United Nations and to all governmental and nongovernmental organizations that have helped WHO to attain its objectives in this respect;

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

Hbk Res., Vol. II (3rd ed.), 1.4.3 (Seventeenth plenary meeting, 23 May 1980 - Committee B, fourth report)

WHA33.24  Formulating strategies for health for all by the year 2000: Health as an integral part of development and of the New International Economic Order

The Thirty-third World Health Assembly,

Recalling resolutions WHA30.43, WHA32.24 and WHA32.30, and convinced that primary health care, as an integral part both of the country's health system and of the overall social and economic development of the community, is the key to health for all, equally valid for all countries, whatever their state of social and economic development;

Recognizing the efforts being made by all countries and WHO in formulating strategies for health for all by the year 2000 in response to the Declaration of Alma-Ata;

Recalling United Nations General Assembly resolutions 3201 (S-VI), 3202 (S-VI), 3281 (XXIX) and 3362 (S-VII) relating to the establishment of a New International Economic Order;

Welcoming resolution 34/58 of 29 November 1979 of the United Nations General Assembly concerning health as an integral part of development, which endorsed the Declaration of Alma-Ata, welcomed the efforts of WHO and UNICEF to attain health for all by the year 2000, and called upon the relevant bodies of the United Nations system to coordinate with and support the efforts of WHO by appropriate actions within their respective spheres of competence, and, in connexion with the preparation of the New International Development Strategy to be considered during the Special Session of the United Nations General Assembly to be held in 1980, called for careful attention to be given to WHO's contribution, which will reflect the global strategy for health for all;

Reaffirming that health is a powerful lever for socioeconomic development and for peace, and that in turn a genuine policy of peace, détente and disarmament could and should release additional resources for attaining health for all by the year 2000, which is essential for raising the quality of human life; and stressing the role of WHO in promoting such a process;

Bearing in mind the fundamental nature of the New International Economic Order and that its effective establishment will be greatly facilitated if due attention is paid to health
and related social development as well as economic development in view of their reciprocally supportive nature;

Concerned by the progressive deterioration of the economies of many developing countries and the consequent stagnation of their social development, including health, and solemnly proclaiming that, for the establishment of a just and equitable New International Economic Order and the formulation of a New International Development Strategy with tangible and positive results for the developing countries, increased efforts of the international community in health and related social fields are vital;

Welcoming the fruitful outcome of the Technical Discussions at the Thirty-third World Health Assembly on the contribution of health to the New International Economic Order;

1. CALLS on Member States:

(1) to respond in concrete terms to the substance and the spirit of the resolutions mentioned in the preamble, as adopted, and to use them constructively in order to promote health and development in the spirit of the Alma-Ata Declaration, including the principles of national political commitment and self-reliance in health matters;

(2) to urge their delegates to the Preparatory Committee for the New International Development Strategy to take active steps to ensure that, in the light of resolution 34/58 of the United Nations General Assembly, health receives prominent attention in the debate, in the final document and in resulting programme activities;

2. THANKS the Executive Board for its progress report on "Formulating strategies for health for all by the year 2000",1 welcoming the cooperation that is taking place among Member States and between WHO and its Member States for the development of these strategies;

3. REQUESTS the Executive Board:

(1) to ensure that the Organization's programmes constantly support the formulation and refinement of national, regional and global strategies for health for all as well as the monitoring of their implementation;

(2) to ensure that the programmes of WHO in the fields of its competence are formulated and implemented in the spirit of the New International Economic Order wherever applicable, with due regard to activities in national, multinational and international trade and industry in the health sector, the transfer of resources and technology, as well as other factors relating to health that would contribute to accelerated harmonious and balanced human development in developing countries;

4. REQUESTS the Director-General:

(1) to take full advantage of the international climate of support at all levels and in all sectors for achieving the health goals of the Organization, through the recognition by all Member States and the whole United Nations system of the essential role of health in development and their endorsement of the Declaration of Alma-Ata and of WHO's main goal of health for all by the year 2000;

(2) in particular, to respond effectively to the request of the United Nations General Assembly in its resolution 34/58 concerning WHO's contribution to the New International Development Strategy and the work of international organizations with primary responsibilities in other sectors;

1 See Annex 4.
(3) to continue to support Member States both individually, and collectively in the regional committees and the Health Assembly, in their efforts to formulate, implement and monitor strategies for health for all;

(4) to report to the Thirty-fourth World Health Assembly in 1981 on steps taken for the implementation of the United Nations General Assembly resolution 34/58 and resolution WHA32.24.

WHA33.25 Development and coordination of biomedical and health services research

The Thirty-third World Health Assembly,

Having considered the Director-General's progress report on the development and coordination of biomedical and health services research;¹

Recalling resolutions WHA25.60, WHA27.61, WHA28.70, WHA29.64, WHA30.40 and WHA32.15;

Affirming that biomedical, health services and health promotion research in particular, and science in general, should be a major accelerator of the progress of all Member States towards health for all by the year 2000;

Recognizing that such research can only be effective if it relies on both strengthened national capabilities and international coordination;

Noting with concern that the achievements of biomedical and medicosocial sciences have not been accompanied by a decrease of the gap between the developed and developing countries in generating and applying scientific knowledge relevant to health development and promotion; that most developing countries still lack the resources, manpower and infrastructure necessary for health research; and that in many developed countries also the efforts and resources devoted to health research are inadequate;

1. URGES Member States:

(1) to ensure that biomedical, psychosocial and health services research is included in their national policies, plans and budget allocations related to the goal of health for all by the year 2000;

(2) to intensify their cooperation, and particularly the cooperation between developed and developing countries:

   (a) in building up or upgrading the health research capability of developing countries in its various forms, including separate research institutes, research arms of universities, components of specific health programmes or projects, and the creation of national coordinating mechanisms;

   (b) in ensuring that an effective strengthening of national research capability of developing countries is the net result of every collaborative research activity;

(3) to give high priority to research training and to measures that encourage scientists from developing countries completing their studies in developed countries to return home and apply their skills and knowledge there, as follows:

¹ Document A33/9.
(a) developing countries should offer appropriate incentives, and
(b) countries providing the training should refrain both from encouraging such scientists to remain there and from offering them facilities that could act as disincentives to returning to their own country;

2. DECIDES that the Health Assembly and the Executive Board shall monitor and evaluate the effectiveness of the Organization's programmes in biomedical and health services research, as well as policies aiming to improve the research capabilities of developing countries;

3. REQUESTS the Director-General:

1. to strengthen the global leadership of the Organization in the worldwide coordination and steering of research necessary for the attainment of health for all by the year 2000, by:

(a) intensifying the coordinating functions of WHO and reinforcing the actual implementation of research activities by Member States and institutions and individuals, particularly in developing countries, and utilizing, inter alia, the medium-term programmes for research promotion and development to this end;

(b) creating and maintaining within the Organization at all levels, and especially at the global level, a blend of scientific expertise of highest quality, which should be at the disposal of Member States in their efforts to harness research to national strategies for health development;

(c) expanding the involvement of scientists from developing and developed countries in the Organization's research programmes, and utilizing fully the global and regional Advisory Committees on Medical Research;

(d) studying the possibility of setting up multidisciplinary groups of experts to evaluate progress in research and to examine ways and means of ensuring the speedy application of the results within programmes so that the benefits facilitate the attainment of the target of health for all by the year 2000;

2. to cooperate with Member States in carrying out a thorough assessment of their current capabilities and needs regarding research and in mobilizing the intellectual and material resources of the Organization to improve such capabilities and meet needs;

3. to take vigorous measures to increase extrabudgetary support for health research that is coordinated or sponsored by WHO and to concentrate both the Organization's regular budget and its extrabudgetary funds for research on programmes that are most relevant for attaining health for all by the year 2000;

4. to improve the mechanisms for the dissemination of biomedical and health services research information;

5. to submit to the Thirty-fifth World Health Assembly a report on the progress achieved in the implementation of this resolution.

Hbk Res., Vol. II (3rd ed.), 1.5 (Seventeenth plenary meeting, 23 May 1980 - Committee A, second report)
WHA33.26 Tuberculosis control

The Thirty-third World Health Assembly,

Noting with concern that tuberculosis remains one of the most important health problems in developing countries, and that efforts in control programmes and resources for research on the application of tuberculosis control measures are still inadequate or have been sharply reduced in the last decade;

Emphasizing that technology in tuberculosis control has been simplified to such a degree that it is applicable under practically any circumstances, and thus is eminently applicable at the community and individual levels as part of primary health care;

Recognizing that the discovery of new, potent, bactericidal drugs facilitates a considerable shortening of the duration of antituberculosis chemotherapy, though the danger of drug resistance remains;

Noting that the Indian Council for Medical Research and WHO are currently reviewing the varying results of the various controlled BCG trials, in particular the tuberculosis prevention trial at present in progress in the South of India;

1. URGES Member States to give earliest attention to the application of tuberculosis control as an integral component of primary health care;

2. REQUESTS the Director-General:

(1) to present a review of the tuberculosis situation in the world and of the implementation of national tuberculosis control programmes to the Thirty-fifth World Health Assembly in 1982;

(2) to revive and promote new interest in research on the actual delivery of the tuberculosis control programme at the primary health care level and on the further simplification, if possible, of the diagnostic and treatment procedures, as well as on the effectiveness of the preventive measures;

(3) to take adequate steps to ensure that antituberculosis drugs become more widely available in developing countries, within the programme on essential drugs, at the lowest possible cost;

(4) to take appropriate measures to increase the extrabudgetary support for health research on integrated tuberculosis control programmes and to secure adequate allocations from the Organization’s regular budget for promoting national programmes in developing countries.

Hbk Res., Vol. II (3rd ed.), 1.10.3.2 (Seventeenth plenary meeting, 23 May 1980 - Committee A, second report)

WHA33.27 Action in respect of international conventions on narcotic and psychotropic substances: Abuse of narcotic and psychotropic substances

The Thirty-third World Health Assembly,

Acknowledging the role and responsibilities of WHO in relation to the abuse of narcotic and psychotropic substances;

Noting reports concerning the growing incidence of abuse of heroin and other opiates, cocaine, coca paste, cannabis, barbiturates and non-barbiturate sedative hypnotics, tranquillizers, and other psychoactive drugs;
Noting the increase in drug-related deaths, particularly as a result of overdoses, combinations of drugs with other drugs and with alcohol, and dangerous impurities; the increasing drug abuse especially among young people and women; and the severe health and social problems related to this abuse;

Recognizing that drug abuse is a serious obstacle to socioeconomic progress and has a particularly negative impact on public health;

Reaffirming resolutions WHA26.52 and WHA28.80 concerning, respectively, the epidemiology of drug dependence and the need for programmes of prevention, treatment and rehabilitation in the field of drug dependence at the community level;

Noting with appreciation the work done by WHO in cooperation with the United Nations Fund for Drug Abuse Control, in particular regarding epidemiological research and reporting, the holding of seminars on the safe use of psychotropic and narcotic substances, and the convening of an expert committee on the assessment of untoward consequences for public health of drug dependence and abuse;

Having noted the request of the United Nations General Assembly in resolution 32/124 (1977) that, in the effort to reduce drug abuse, WHO and other appropriate agencies and bodies of the United Nations design models for prevention, treatment and rehabilitation;

Acknowledging United Nations General Assembly resolution 34/177 (1979), urging greater action by WHO and other United Nations agencies to implement drug abuse control programmes within their mandates, and requesting that they make drug abuse control a regular item on the agendas of their governing bodies;

1. **AFFIRMS** that drug abuse constitutes a serious health hazard of steadily growing proportions in developing nations as well as industrialized countries;

2. **URGES** Member States to devote more attention to the incidence of drug abuse in their own societies, their regions and the world community, and particularly to the disruptive effect that drug abuse has on the lives and future careers of young people, to its negative impact on socioeconomic well-being, to the increasing difficulties in enforcing the law, and to measures aimed at reducing the incidence of illicit supply of drugs of abuse in their societies;

3. **ENCOURAGES** Member States, as they develop their national strategies for health for all by the year 2000, and their biennial programmes of cooperation with WHO, to give serious consideration to the inclusion of components that can deal effectively with the growing incidence of drug abuse;

4. **INVITES** Member States to make voluntary contributions to support work in the field of drug abuse control by WHO and other international bodies, particularly the United Nations Fund for Drug Abuse Control;

5. **URGES** Member States that have not done so to become parties to the international drug control treaties as soon as possible;

6. **RECOMMENDS** that WHO continue to assess the impact of primary health care on the reduction of local dependence on opium as a panacea, particularly in opium-producing countries;

7. **REQUESTS** the Director-General:

   (1) to foster the collection, processing and dissemination, through publication and other means, of information relating to the detrimental effects of drug abuse on health and social development;

   (2) to collaborate with Member States in integrating drug abuse control into their primary health care programmes and national strategies for health for all by the year 2000;
(3) to promote the initiation and strengthening of national and international programmes for the assessment, scheduling, control and appropriate use of narcotic and psychotropic substances, including those of plant origin, and to support such programmes by the development of appropriate guidelines in consultation with the United Nations Division of Narcotic Drugs, International Narcotics Control Board and other United Nations bodies concerned;

(4) to seek additional funds from multilateral, governmental and nongovernmental sources for the support of new projects and WHO programmes in drug abuse control;

(5) to further develop activities concerned with the prevention and control of health problems related to human behaviour, such as those associated with drug abuse;

(6) to maintain WHO's capacity to deal with this pressing health issue;

(7) to strengthen the coordination between the WHO programmes relating to narcotic and psychotropic substances, those dealing with drug policy and management, and other related programmes, and to strengthen collaboration with interested nongovernmental organizations;

(8) to report to the Health Assembly whenever appropriate on progress in implementing the provisions of this resolution.

Hbk Res., Vol. II (3rd ed.), 1.8.4.1

WHA33.28 Strengthening WHO's health legislation programme

The Thirty-third World Health Assembly,

Recognizing that obsolete health legislation may constitute an obstacle at the national level to the attainment of health for all;

Noting that appropriate health legislation is an essential component of health care services and environmental health systems for the delivery of both personal and environmental health services;

Having considered the report of the Director-General on the strengthening of WHO's health legislation programme¹ and the comments of the Executive Board thereon;²

1. CONSIDERS that the proposed reorientation of the health legislation programme, in pursuance of resolution WHA30.44, fully reflects the new health policies of WHO and its Member States;

2. REQUESTS the Director-General to proceed with the formulation of a detailed programme of technical cooperation and information transfer in health legislation, on the basis of the strategies presented in his report.


WHA33.29  Reservations to the International Health Regulations (1969)

The Thirty-third World Health Assembly,

Having noted the Director-General's report1 on reservations to the International Health Regulations (1969) and the requests contained therein for a further extension of certain existing reservations;

1. APPROVES the extension without time limit of the reservations made by Egypt to Article 3, paragraph 1, and Article 4, paragraph 1;

2. APPROVES the extension without time limit of the reservations made by India to Article 3, paragraph 1, Article 4, paragraph 1, Article 7, paragraph 2(b), and Article 43;

3. APPROVES the extension without time limit of the reservations made by Pakistan to Article 3, paragraph 1, Article 4, paragraph 1, Article 7, paragraph 2(b), Article 43, and Article 88.

Hbk Res., Vol. II (3rd ed.), 1.10.1.1 (Seventeenth plenary meeting, 23 May 1980 - Committee B, fifth report)

WHA33.30  Recruitment of international staff in WHO

The Thirty-third World Health Assembly,

Having considered the Director-General's report on the recruitment of international staff in WHO2 submitted to the Executive Board pursuant to resolution WHA32.37, and the comments made thereon by the members of the Executive Board;3


Considering also resolution 34/219 of the United Nations General Assembly;

1. NOTES with appreciation the continued efforts made by the Director-General to achieve a more balanced and equitable geographical distribution of professional and higher graded staff, and the progress he has made towards achieving the targets approved by the Executive Board at its sixty-third session;

2. REQUESTS the Director-General to continue to pursue that goal in recruiting staff, in accordance with his prerogatives under Article 35 of the Constitution;

3. REAFFIRMS that the principle of recruiting on as wide a geographical basis as possible, with due regard to quality, efficiency, and integrity, in pursuance of Article 35 of the Constitution and Staff Regulation 4.2, should apply to all appropriate internationally recruited staff posted throughout the world, regardless of the source of funding of the posts involved;

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1 See Annex 5.
4. CONCURS in the Executive Board's decision\(^1\) to defer its re-examination of the concept of desirable ranges until after consideration by the United Nations General Assembly of the information called for in its resolution 34/219, including the principle of weighting;

5. REQUESTS the Executive Board to report on this matter to the Thirty-fourth World Health Assembly.

Hbk Res., Vol. II (3rd ed.), 7.2.2 (Seventeenth plenary meeting, 23 May 1980 - Committee B, fifth report)

WHA33.31 Workers' health programme

The Thirty-third World Health Assembly,

Having examined the summary of the programme of action on workers' health, contained in the Director-General's report\(^2\) on this subject;

Confirming the importance and validity of resolution WHA32.14 which views with much concern the magnitude of health problems suffered by the underserved working populations, mainly workers in agriculture, small industries and construction, and migrant workers, who constitute the majority of working populations throughout the world;

Aware of the growing health problems related to child labour, where it exists, as well as to mining;

Stressing the particular obligations of all those responsible in the government, the economy and other sectors of society for the establishment and maintenance of safe working conditions and thus for meeting the requirements of workers' health protection;

Convinced that there is a growing need for a new perspective integrating occupational health in the primary health care of underserved working populations, particularly in the developing countries;

Recalling that, for setting and implementing strategies for health for all by the year 2000, it is necessary to promote occupational health services and to strengthen institutions, training and research in this field;

Noting that the response to the call for voluntary contributions to this field has so far been limited;

1. ENDORSES the programme of action on workers' health summarized in the progress report and requests the Director-General to implement it;

2. URGES Member States to pay special attention to the provision of health care to working populations, particularly underserved workers, including migrant workers, miners and working children, where applicable, and to contribute financially and/or otherwise to WHO's programme of action in this field;

3. INVITES industries, voluntary agencies, nongovernmental organizations and individuals to contribute, both in funds and in kind, to WHO's work in this field;

4. REQUESTS the Director-General:

(1) to implement in decisive steps the programme of action on workers' health, taking into account the proposals for the Organization's future activities made during the discussions, and to allocate necessary funds in the regular budget for this purpose;

\(^1\) Document EB65/1980/REC/1, decision (17).
\(^2\) Document A33/12.
to support the developing countries in ensuring safe working conditions and effective protective measures for workers' health in agriculture, in mining and in industrial enterprises which already exist or which will be set up in the process of industrialization, by using the experience available in this field in both industrialized and developing countries and by designating more WHO collaborating centres for occupational health in the developing countries;

(3) to approach governments and other potential donors to seek extrabudgetary funds for the Voluntary Fund for Health Promotion to be used for implementing this programme;

(4) to continue his dialogue with ILO and other United Nations agencies with a view to developing mechanisms of coordination and strengthening cooperation in this field;

(5) to study, in cooperation with ILO and other United Nations agencies concerned, different examples of the role of various ministries in the field of occupational health and control of the working environment, and to cooperate with Member States upon request by offering guiding principles based on these studies;

(6) to submit progress reports to future Health Assemblies on the implementation of this programme of action.

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

(Seventeenth plenary meeting, 23 May 1980 - Committee A, third report)

WHA33.32 Infant and young child feeding

The Thirty-third World Health Assembly,

Recalling resolutions WHA27.43 and WHA31.47 which in particular reaffirmed that breastfeeding is ideal for the harmonious physical and psychosocial development of the child, that urgent action is called for by governments and the Director-General in order to intensify activities for the promotion of breastfeeding and development of actions related to the preparation and use of weaning foods based on local products, and that there is an urgent need for countries to review sales promotion activities on baby foods and to introduce appropriate remedial measures, including advertisement codes and legislation, as well as to take appropriate supportive social measures for mothers working away from their homes during the lactation period;

Recalling further resolutions WHA31.55 and WHA32.42 which emphasized maternal and child health as an essential component of primary health care, vital to the attainment of health for all by the year 2000;

Recognizing that there is a close interrelationship between infant and young child feeding and social and economic development, and that urgent action by governments is required to promote the health and nutrition of infants, young children and mothers, inter alia through education, training and information in this field;

Noting that a joint WHO/UNICEF Meeting on Infant and Young Child Feeding was held from 9 to 12 October 1979, and was attended by representatives of governments, the United Nations system and technical agencies, nongovernmental organizations active in the area, the infant food industry and other scientists working in this field;

1. ENDORSES in their entirety the statement and recommendations made by the joint WHO/UNICEF Meeting, namely on the encouragement and support of breastfeeding; the promotion and support of appropriate weaning practices; the strengthening of education, training and

1 See Annex 6.
information; the promotion of the health and social status of women in relation to infant and young child feeding; and the appropriate marketing and distribution of breastmilk substitutes. This statement and these recommendations also make clear the responsibility in this field incumbent on the health services, health personnel, national authorities, women's and other nongovernmental organizations, the United Nations agencies and the infant-food industry, and stress the importance for countries to have a coherent food and nutrition policy and the need for pregnant and lactating women to be adequately nourished; the joint Meeting also recommended that "There should be an international code of marketing of infant formula and other products used as breastmilk substitutes. This should be supported by both exporting and importing countries and observed by all manufacturers. WHO and UNICEF are requested to organize the process for its preparation, with the involvement of all concerned parties, in order to reach a conclusion as soon as possible";

2. RECOGNIZES the important work already carried out by the World Health Organization and UNICEF with a view to implementing these recommendations and the preparatory work done on the formulation of a draft international code of marketing of breastmilk substitutes;

3. URGES countries which have not already done so to review and implement resolutions WHA27.43 and WHA32.42;

4. URGES women's organizations to organize extensive information dissemination campaigns in support of breastfeeding and healthy habits;

5. REQUESTS the Director-General:

   (1) to cooperate with Member States on request in supervising or arranging for the supervision of the quality of infant foods during their production in the country concerned, as well as during their importation and marketing;

   (2) to promote and support the exchange of information on laws, regulations, and other measures concerning marketing of breastmilk substitutes;

6. FURTHER REQUESTS the Director-General to intensify his activities for promoting the application of the recommendations of the joint WHO/UNICEF Meeting and, in particular:

   (1) to continue efforts to promote breastfeeding as well as sound supplementary feeding and weaning practices as a prerequisite to healthy child growth and development;

   (2) to intensify coordination with other international and bilateral agencies for the mobilization of the necessary resources for the promotion and support of activities related to the preparation of weaning foods based on local products in countries in need of such support and to collate and disseminate information on methods of supplementary feeding and weaning practices successfully used in different cultural settings;

   (3) to intensify activities in the field of health education, training and information on infant and young child feeding, in particular through the preparation of training and other manuals for primary health care workers in different regions and countries;

   (4) to prepare an international code of marketing of breastmilk substitutes in close consultation with Member States and with all other parties concerned including such scientific and other experts whose collaboration may be deemed appropriate, bearing in mind that:

   (a) the marketing of breastmilk substitutes and weaning foods must be viewed within the framework of the problems of infant and young child feeding as a whole;

   (b) the aim of the code should be to contribute to the provision of safe and adequate nutrition for infants and young children, and in particular to promote
breastfeeding and ensure, on the basis of adequate information, the proper use of breastmilk substitutes, if necessary;

(c) the code should be based on existing knowledge of infant nutrition;

(d) the code should be governed inter alia by the following principles:

(i) the production, storage and distribution, as well as advertising, of infant feeding products should be subject to national legislation or regulations, or other measures as appropriate to the country concerned;

(ii) relevant information on infant feeding should be provided by the health care system of the country in which the product is consumed;

(iii) products should meet international standards of quality and presentation, in particular those developed by the Codex Alimentarius Commission, and their labels should clearly inform the public of the superiority of breastfeeding;

(5) to submit the code to the Executive Board for consideration at its sixty-seventh session and for forwarding with its recommendations to the Thirty-fourth World Health Assembly, together with proposals regarding its promotion and implementation, either as a regulation in the sense of Articles 21 and 22 of the Constitution of the World Health Organization or as a recommendation in the sense of Article 23, outlining the legal and other implications of each choice;

(6) to review the existing legislation in different countries for enabling and supporting breastfeeding, especially by working mothers, and to strengthen the Organization's capacity to cooperate on the request of Member States in developing such legislation;

(7) to submit to the Thirty-fourth World Health Assembly, in 1981, and thereafter in even years, a report on the steps taken by WHO to promote breastfeeding and to improve infant and young child feeding, together with an evaluation of the effect of all measures taken by WHO and its Member States.

Hbk Res., Vol. II (3rd ed.), 1.7.1 (Seventeenth plenary meeting, 23 May 1980 - Committee A, third report)

WHA33.33 Cooperation with newly independent and emerging States in Africa:
Liberation struggle in Southern Africa - Assistance to front-line States

The Thirty-third World Health Assembly,

Taking into account the decisions set forth in resolutions WHA29.23, WHA30.24, WHA31.52 and WHA32.20;

Aware of the escalation and intensification of the acts of aggression committed against the People's Republic of Angola and the Republic of Zambia and the bombing of their civilian populations by the racist regime of South Africa, as well as the provocations and measures of economic blackmail against the sovereignty of Botswana and Lesotho;

Taking into account the fact that the so-called "internal settlement" in Namibia constitutes another threat to the security and welfare of the peoples of Angola and Zambia;

Considering that the policy of the racist regime of South Africa is leading to a considerable increase in the number of refugees in Angola, Botswana, Lesotho, Mozambique, Swaziland and Zambia, forcing them to live under sanitary conditions conducive to the outbreak of epidemics;
Noting that most of the refugees from Zimbabwe have not yet returned home and that their repatriation is a slow process which will be completed only towards the end of 1980;

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

Taking into account the sacrifices made by the host countries to ensure the minimum hygienic and health conditions needed by the refugees;

Taking also into account the enormous difficulties that the front-line States have met with in their effort to rebuild the health infrastructures destroyed by the repeated acts of aggression of the illegal regime of Ian Smith and the racist regime of South Africa;

1. REITERATES its satisfaction at 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, and WHO in their action on behalf of technical cooperation with the above-mentioned States;

2. THANKS the Director-General for his commitment to technical cooperation with the above-mentioned States;

3. GIVES its full support to the front-line States and to Lesotho and Swaziland in their efforts on behalf of refugees from countries under colonial and racist domination;

4. REQUESTS the Director-General:

   (1) to intensify cooperation in the health sphere with the front-line States which are subjected to repeated aggressions by the racist regime of South Africa and with Lesotho and Swaziland which are subjected to provocations and measures of economic blackmail by that regime;

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

   (3) to continue making every possible effort to obtain the necessary governmental and nongovernmental support for an emergency programme of assistance to the front-line States, Lesotho, and Swaziland;

   (4) to sustain and continue his assistance in improving the health conditions of the peoples participating in the liberation movements recognized by the Organization of African Unity;

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

Hbk Res., Vol. II (3rd ed.), 1.4.2 (Seventeenth plenary meeting, 23 May 1980 - Committee B, sixth report)
Noting with concern the devastating effects of the war from which Zimbabwe has just emerged;

Realizing therefore that the new Republic of Zimbabwe does not have sufficient resources to meet the health requirements of its people;

Expressing its satisfaction with the concerted efforts made by the Director-General to help the liberation movement of Zimbabwe while under foreign domination;

1. EXPRESSES its satisfaction at the achievement of independence by Zimbabwe and welcomes Zimbabwe as a new Member of the World Health Organization;

2. REQUESTS the Director-General:

   (1) to extend, in collaboration with the United Nations, specialized agencies and other bodies, all necessary assistance in the health sector to the new Republic of Zimbabwe, including the training of health personnel, cooperation in the technical field, and provision of medical supplies;

   (2) to take all possible measures to encourage and facilitate cooperation between all Member States and Zimbabwe, especially in the field of technical cooperation among developing countries;

   (3) to present a report to the Thirty-fourth World Health Assembly on the progress made in the implementation of this resolution.

Hbk Res., Vol. II (3rd ed.), 1.4.2 (Seventeenth plenary meeting, 23 May 1980 - Committee B, sixth report)

WHA33.35  

WHO's programme on smoking and health

The Thirty-third World Health Assembly,

Recalling resolutions EB45.R9, WHA23.32, EB47.R42, WHA24.48, EB53.R31, WHA29.55, and WHA31.56 concerning the health hazards of tobacco smoking and WHO’s role in the limitation of this harmful habit;

Noting the report of the WHO Expert Committee on Smoking Control;

Reiterating its firm conviction that the effect of tobacco smoking is now a major public health problem in all industrialized countries and in many developing countries and that it will become so in the near future in all other developing countries unless action is taken now;

Mindful of the ill-effects of smoking, particularly on risk groups such as pregnant women, lactating mothers and children;

Seriously concerned about the aggressive promotional drives for the sale of cigarettes that occur in developing as well as developed countries, thus inducing the new generations to take up the habit of smoking;

Alarmed by the fact that advertising practices using psychological means in both industrialized and developing countries have the effect of inducing and perpetuating smoking habits, especially among youth;

1 See Annex 7.

Encouraged by the existence of total bans, restrictions or limitations on tobacco advertising in several countries;

Noting encouraging signs of expanded national activities and of increasing public awareness of the harmful health effects of cigarette smoking in many countries, partly as a result of WHO’s efforts and of this year’s World Health Day on "Smoking or health: the choice is yours";

Realizing that national and international strategies to combat the spreading of the habit of smoking must be carried out on a continuous, long-term basis;

Believing that WHO has an essential role to play in promoting effective smoking control policies;

1. URGES Member States:

   (1) to strengthen, and to initiate where lacking, the smoking control strategies outlined in the above-mentioned resolutions, laying special emphasis on educational approaches, particularly with respect to youth, and on measures to ban, restrict or limit advertising of tobacco products;

   (2) to support WHO’s action in the field of smoking and health;

2. REQUESTS the Director-General:

   (1) to further develop an effective WHO action programme on smoking and health, clearly defining lines of responsibility and priority areas, and taking into account the multi-disciplinary and intersectoral character of the relationship between smoking and health;

   (2) to ensure that WHO plays a leading role in coordinating international activities and to strengthen collaboration with other United Nations agencies and with relevant nongovernmental organizations, and, particularly, to pursue the study on crop diversification in tobacco-growing areas in collaboration with FAO;

   (3) to collaborate with Member States in their efforts to reduce smoking;

   (4) to consider problems caused by the marketing and consumption of tobacco, particularly in developing countries;

   (5) to mobilize financial and other resources for the implementation of the programme;

   (6) to report on progress of this programme to the Thirty-fifth World Health Assembly.

Hbk Res., Vol. II (3rd ed.), 1.11.6 (Seventeenth plenary meeting, 23 May 1980 - Committee B, seventh report).
DECISIONS

(1) Composition of the Committee on Credentials

The Thirty-third World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Member States: Djibouti; German Democratic Republic; Greece; Guinea-Bissau; Guyana; Iceland; India; Mauritius; Paraguay; Qatar; Rwanda; and Tonga.

(First plenary meeting, 5 May 1980)

(2) Composition of the Committee on Nominations

The Thirty-third World Health Assembly elected a Committee on Nominations consisting of delegates of the following 24 Member States: Argentina; Bangladesh; Benin; Burundi; Canada; China; El Salvador; France; Gambia; Jordan; Lebanon; Mauritania; Pakistan; Panama; Papua New Guinea; Sao Tome and Principe; Somalia; Spain; Swaziland; Thailand; Union of Soviet Socialist Republics; United Kingdom of Great Britain and Northern Ireland; Venezuela; and Yugoslavia.

(First plenary meeting, 5 May 1980)

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

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

President: Dr A. R. Al-Awadi (Kuwait)

Vice-Presidents:

Dr A. N. Acosta (Philippines), Professor R. Vannugli (Italy),
Dr S. Surjaningrat (Indonesia), Dr H. Garcia Barrios (Venezuela),
Dr P. Mocumbi (Mozambique)

(Second plenary meeting, 6 May 1980)

(4) Election of officers of the main committees

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

COMMITTEE A: Chairman, Dr Elizabeth Quamina (Trinidad and Tobago)

COMMITTEE B: Chairman, Dr E. M. Samba (Gambia)

(Second plenary meeting, 6 May 1980)
The main committees subsequently elected the following officers:

COMMITTEE A: Vice-Chairmen, Dr E. G. Beausoleil (Ghana) and Dr N. W. Tavil (Papua New Guinea); Rapporteur, Mr N. N. Vohra (India);

COMMITTEE B: Vice-Chairmen, Mr D. J. de Geer (Netherlands) and Mr B. C. Perera (Sri Lanka); Rapporteur, Mrs T. Raivio (Finland).

(First meetings of Committees A and B, 8 May 1980)

(5) Establishment of the General Committee

The Thirty-third 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: Angola; Argentina; Benin; Botswana; Burundi; Chile; China; Czechoslovakia; France; Iraq; Saudi Arabia; Sri Lanka; Sudan; Union of Soviet Socialist Republics; United Kingdom of Great Britain and Northern Ireland; and United States of America.

(Second plenary meeting, 6 May 1980)

(6) Adoption of the agenda

The Thirty-third World Health Assembly adopted the provisional agenda prepared by the Executive Board at its sixty-fifth session with the addition of two sub-items and the deletion of two items.

(Third plenary meeting, 6 May 1980)

(7) Verification of credentials

The Thirty-third 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 Republic; Chile; China; Colombia; Comoros; Congo; Costa Rica; Cuba; Cyprus; Czechoslovakia; Democratic Kampuchea; Democratic People's Republic of Korea; Democratic Yemen; Denmark; Dominican Republic; Ecuador; Egypt; El Salvador; Ethiopia; 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; 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; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Seychelles; 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; Zambia; and Zimbabwe.

Associate Member

Namibia.

(Fifth, eleventh and seventeenth plenary meetings, 7, 14 and 23 May 1980)

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

The Thirty-third 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: Brazil; Canada; Gabon; Gambia; Guatemala; Kuwait; Mongolia; Romania; United Kingdom of Great Britain and Northern Ireland; and Yemen.

(Eleventh plenary meeting, 14 May 1980)


The Thirty-third World Health Assembly, after reviewing the Director-General's report on the work of the Organization in 1978-1979,2 noted with satisfaction the manner in which the Organization's programme for this biennium had been planned and implemented.

(Eleventh plenary meeting, 14 May 1980)

(10) Reports of the Executive Board on its sixty-fourth and sixty-fifth sessions

The Thirty-third World Health Assembly, after reviewing the Executive Board's reports on its sixty-fourth3 and sixty-fifth4 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 Assembly.

(Eleventh plenary meeting, 14 May 1980)

1 For report of the General Committee, see document WHA33/1980/REC/2.
3 Document EB64/1979/REC/1.
(11) Sixth General Programme of Work covering a specific period (1978-1983 inclusive): Annual review and progress report on medium-term programming for the implementation of the Sixth General Programme of Work

The Thirty-third World Health Assembly took note of Executive Board resolution EB65.R4 and expressed its satisfaction with the progress made in converting the Sixth General Programme of Work into medium-term programmes, as illustrated by the medium-term programme for comprehensive health services contained in the Director-General's report.¹

(Seventeenth plenary meeting, 23 May 1980)


The Thirty-third World Health Assembly noted the report of the Director-General on changes in the programme budget for 1980-1981.²

(Seventeenth plenary meeting, 23 May 1980)

(13) UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases

The Thirty-third World Health Assembly, having noted the progress report of the Director-General on the Special Programme for Research and Training in Tropical Diseases,³ complimented the Director-General on the rapid and effective implementation of all areas of the Programme. The Assembly expressed its pleasure with the significant progress already made and its appreciation for the scientific and financial contributions to the Programme by over 80 Member States. It requested the Director-General to continue the development and operation of the Programme along the lines described in his progress report and to continue to make budgetary provisions for the Programme, to be used according to the approved priorities of the Programme.

(Seventeenth plenary meeting, 23 May 1980)

(14) Annual report of the United Nations Joint Staff Pension Board for 1978

The Thirty-third World Health Assembly noted the status of the operation of the Joint Staff Pension Fund, as indicated by the annual report of the United Nations Joint Staff Pension Board for the year 1978⁴ and as reported by the Director-General.

(Seventeenth plenary meeting, 23 May 1980)

¹ Document A33/7.
² Documents A33/8 and EB65/1980/REC/1, p. 35.
³ Document A33/10.
⁴ Document A33/27.
(15) Appointment of representatives to the WHO Staff Pension Committee

The Thirty-third World Health Assembly appointed the member of the Executive Board designated by the Government of Brazil as member of the WHO Staff Pension Committee, and the member of the Board designated by the Government of Mongolia as alternate member of the Committee, the appointments being for a period of three years.

(Seventeenth plenary meeting, 23 May 1980)

(16) Malaria control strategy

The Thirty-third World Health Assembly reviewed the progress report by the Director-General on malaria control strategy\(^1\) and noted that the Executive Board would undertake a more detailed study on the implementation of the strategy.

(Seventeenth plenary meeting, 23 May 1980)

(17) Clean water and adequate sanitation for all by 1990

The Thirty-third World Health Assembly requested the Director-General, in implementing WHO's technical cooperation as outlined in his report,\(^2\) to give particular emphasis to strengthening the role of national health agencies and to the application of primary health care principles in supporting national action for the International Drinking-Water Supply and Sanitation Decade, 1981-1990. The Health Assembly further requested the Director-General to continue close cooperation with official donor agencies and international development banks to help in attracting additional external funding, and to cooperate with Member States as appropriate in following up the meeting of these agencies to be held at WHO headquarters in June 1980.

(Seventeenth plenary meeting, 23 May 1980)

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

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

(Seventeenth plenary meeting, 23 May 1980)

\(^1\) Document A33/13.

\(^2\) Document A33/15.
ANNEXES
ANNEX 1

UNPAID CONTRIBUTIONS OF SOUTHERN RHODESIA

Report by the Director-General

1. The Health Assembly may wish to consider what action should be taken with regard to the contributions recorded as being due by Southern Rhodesia.

2. Southern Rhodesia was admitted to associate membership by the Third World Health Assembly on 16 May 1950. Following the illegal declaration of independence on 11 November 1965, the Government of the United Kingdom of Great Britain and Northern Ireland withdrew "the authority of the representatives of Southern Rhodesia who were appointed by the former Government to represent Southern Rhodesia at the World Health Organization".

3. Southern Rhodesia ceased paying its assessed contributions in the course of 1967. The unpaid contributions of Southern Rhodesia for the years 1967 to 1971 are included in the budget surpluses for those years, and as such they form part of the non-cash portion of the Assembly Suspense Account.

4. In a communication dated 22 May 1969 the Government of the United Kingdom informed the Director-General as follows:

   Whilst the territory of Southern Rhodesia remains an Associate Member of the World Health Organization, the illegal declaration of independence in 1965 has had the consequence that the associate membership is in suspense so far as Southern Rhodesia's enjoyment of it is concerned. Financial transactions between the Organization and the regime (including the payment of contributions) have been suspended until the return of legality in Southern Rhodesia. 2

5. In view of this communication from the Government of the United Kingdom, it became evident that payment of the contributions of Southern Rhodesia could not be expected to be received and that such non-payment would mean a loss of income to the Organization. In the light of experience and considering the prudent financial measures adopted by the Executive Board and the World Health Assembly in the past, the Director-General recommended that the assessment of Southern Rhodesia be placed in the Undistributed Reserve for 1972 and future years. 3

6. The Twenty-fourth World Health Assembly (1971) accepted the recommendation of the Director-General and in resolution WHA24.14 decided "that in 1972 and future years the amount of the annually assessed contribution of Southern Rhodesia to the regular budget of the Organization shall be placed in the appropriation section for Undistributed Reserve of the annual Appropriation Resolution".

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1 See resolution WHA33.12.
7. Pursuant to resolution WHA24.14 the assessments of Southern Rhodesia for the period 1972 to 1981 have been included in the appropriation section entitled "Undistributed Reserve" of the Appropriation Resolutions adopted each year by the World Health Assembly from 1971 to 1979. Such an appropriation section has since 1952 been included in the Appropriation Resolutions in order to provide in the total budget of the Organization an amount equivalent to the assessed contributions of inactive Members, that is, those Members that have expressed their intention of withdrawing their membership of the Organization despite the lack of constitutional provision permitting such withdrawal and those Members or Associate Members that have ceased to participate in the activities of the Organization and whose membership was considered as being in suspense. In order to ensure that expenditure should not exceed income reasonably expected to be available during a given financial period, the Appropriation Resolutions adopted since 1952 have provided that the obligations to be incurred during the given financial period be limited to the amounts included in the appropriation sections other than that for the Undistributed Reserve. By this method WHO has been able to avoid income deficits in its budgets which were unlikely to be recoverable, while still continuing to assess all Members and Associate Members.

8. As the amounts regularly appropriated for the Undistributed Reserve are parts of the total budgets of WHO against which no obligations can be incurred, they are in effect budgetary surpluses, although non-cash ones. As such, at the end of the relevant financial year or period, like the unpaid contributions of Southern Rhodesia for the years 1967 to 1971 referred to in paragraph 3 above, they are included in the non-cash portion of the Assembly Suspense Account. Consequently, the assessed contributions of Southern Rhodesia for the period 1967 to 1979 ($ 194,720) form part of the non-cash portion of the Assembly Suspense Account; the contribution for the current financial period 1980-1981 ($ 43,300) is a component of section 10 (Undistributed Reserve) of the Appropriation Resolution for the financial period 1980-1981 (resolution WHA32.28), and will be included in the non-cash portion of the Assembly Suspense Account at the end of the financial period.

9. Having regard to the proposed assessment of Zimbabwe, the Director-General proposes that the contributions recorded as being due by Southern Rhodesia for the period 1967 to 1981, amounting to US$ 238,020, be cancelled, and that the paid-up advance by Southern Rhodesia to the Working Capital Fund, amounting to $ 510, be transferred in the Organization's books in favour of Zimbabwe.

10. The deletion of Southern Rhodesia from the Undistributed Reserve has the effect of reducing the total budget and therefore requires an amendment to the Appropriation Resolution for the financial period 1980-1981. The Director-General proposes that this amendment be dealt with under agenda item 38 (Amendment to the scale of assessments to be applied to the second year of the financial period 1980-1981), which involves a further modification of the total budget and the Appropriation Resolution.2

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1 See resolution WHA33.13.
## ANNEX 2

**TRANSFER OF THE REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN**

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1 See resolution WHA33.16.
1. STUDY BY THE EXECUTIVE BOARD

At the request of the Thirty-second World Health Assembly a Working Group established by the Executive Board at its sixty-fourth session carried out a study of all aspects of the question of a transfer of the Regional Office for the Eastern Mediterranean from Alexandria, Arab Republic of Egypt, to another State in the Region.

In accordance with decision (10) of the Executive Board at its sixty-fifth session, this study is transmitted herewith to the Health Assembly for its consideration and decision. The summary record of the Board's deliberations on the subject appears in document EB65/1980/REC/2, pages 254-258. Some minor corrections which were made to the report of the Working Group during the deliberations of the Board are incorporated in the revised version below.

(a) Report of the Working Group

The Working Group established by the Executive Board at its sixty-fourth session (May 1979) in order to study all aspects of the question of a transfer of the WHO Regional Office for the Eastern Mediterranean (EMRO) submits herewith its report, including findings based on visits to the potential new host countries, to enable the Board to report to the Thirty-third World Health Assembly.

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2 Annexed to the Working Group's report were a chronology of actions concerning the question of a transfer of the Regional Office; a document submitted by the Group to the potential host countries; the reports on the subsequent visits to these countries; a synoptic tabular presentation of answers to a check-list established for those visits; and a comparative table of estimated cost differences in nine potential host countries.
I. ESTABLISHMENT, MANDATE AND COMPOSITION OF THE WORKING GROUP

The question of a transfer of the Regional Office for the Eastern Mediterranean (EMRO) was raised at the Thirty-second World Health Assembly and referred to the Executive Board on 25 May 1979 by the following decision:1

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.

The Executive Board considered the subject on 28 May and decided to establish a working group with members from the six WHO regions as follows:2

The Executive Board, acting at the request of the Thirty-second World Health Assembly, examined the report of Sub-Committee A of the special session of the Regional Committee for the Eastern Mediterranean, which had expressed the wish that the Regional Office be transferred from Alexandria, Arab Republic of Egypt, to another State in the Region, and decided to establish a restricted working group consisting of Dr R. Álvarez Gutiérrez, Dr A. M. Fakhro, Dr H. J. H. Hiddlestone, Dr T. Mork, Dr D. B. Sebina and Dr Shwe Tin to study all aspects of the matter and report to the sixty-fifth session of the Board in January 1980 in order to enable the Board to submit its findings to the Thirty-third World Health Assembly. It was understood that if any member of the working group was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the working group.

While Dr Álvarez Gutiérrez attended meetings of the Working Group in May and July 1979, the Director-General was informed in September that neither he nor any alternate would continue to participate in the Group's further work. Dr Fakhro and Dr Mork, who were unable to participate in part of the Group's work, were on those occasions replaced by their respective alternates, Dr Y. Yacoub and Dr O. T. Christiansen.

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1 Document WHA32/1979/REC/1, p. 46, decision (19).
2 Document EB64/1979/REC/1, p. 4, decision (1).
II. ORGANIZATION OF THE GROUP’S WORK

The Working Group held four meetings, on 29 May, 24–25 July and 26–27 September 1979, and 7–8 January 1980. During the third meeting, held in September 1979 in Alexandria, the Group visited the present premises and informed itself on the working of the Regional Office in its present location. Subsequently subgroups or delegated members visited the countries which had offered to act as host to the Regional Office in the event of its transfer, in order to inspect the premises under consideration and to gather all relevant information through discussions with the governments concerned. These visits, which were carried out from September to December 1979 in an order determined by the drawing of lots, had been prepared by correspondence with the potential host governments, including a document submitted to the governments concerned in July 1979 and outlining all questions relating to the choice of a new location for the Regional Office. The reports on the visits included answers to a checklist drawn up by the Working Group which were presented in synoptic tabular form.

On 27 December 1979, the Regional Director received a letter from the Minister of Health of Cyprus expressing interest in the transfer of the Regional Office to Cyprus, if a transfer were finally decided and if other countries of the Region agreed. The letter indicated the willingness of the Government to make the required premises available at a nominal rent; details of the Government’s contribution were to be discussed with a visiting team. On 7 January 1980 the Working Group decided to arrange for a visit of two members to Cyprus to be carried out from 10 to 13 January 1980. The report on this visit and the Working Group’s findings in this respect are contained in the Addendum to this document.1 At the same time the Working Group decided that it would not be in a position, in time to report to the sixty-fifth session of the Executive Board, to carry out a visit with regard to any further invitation that might be received.

III. VISIT TO THE PRESENT LOCATION OF THE REGIONAL OFFICE

During their visit to Alexandria from 27 to 28 September 1979, the members of the Working Group had an opportunity to be briefed by the Regional Director and to observe the functioning of the Regional Office and its staffing as well as to inspect the Office premises. The Group also took this opportunity to draw up a detailed programme of visits to the potential host countries.

The members of the Working Group formed a high opinion of the quality of the Regional Office staff, both international and locally recruited, and were impressed by the excellent team spirit they observed. The Group recognized the fact that many of the locally recruited general service staff might lose their employment as a result of a relocation of the Regional Office. Many of them would face difficulties in securing an equivalent employment outside WHO.

With respect to the Office premises in Alexandria, the members of the Working Group noted the somewhat crowded conditions of the Office but were informed that the need for larger accommodation had been recognized and that active planning for an adaptation of the premises to this need had been undertaken before the question of the transfer arose. The Group therefore supports the desirability of seeking larger accommodation for the Office in line with the Organization’s normal standards of accommodation, which follow the ILO standards.

IV. QUESTIONS RELATING TO THE REMOVAL OF THE REGIONAL OFFICE FROM THE PRESENT LOCATION

1. Introduction

Relocation of the Regional Office from the present site requires consideration of a number of legal, operational, financial and technical aspects. In particular the following points were examined by the Working Group:

- authority and procedure for determining the site of the regional office of a regional organization;

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1 See section (b), p. 59.
- coordination with the United Nations and interested specialized agencies;
- question of denunciation of the existing Host Agreement;
- denunciation of leases;
- termination of staff contracts;
- transitional difficulties for operations.

2. Authority and procedure for determining the site of the regional office of a regional organization

Under Article 44 of the WHO Constitution, "The Health Assembly may, with the consent of a majority of the Members situated within each area so defined/ geographical area in which it is desirable to establish a regional organization", establish a regional organization to meet the special needs of such area". It may be recalled that the First World Health Assembly resolved that the Executive Board should be instructed to carry out the initial establishment of regional organizations (which comprise regional offices and regional committees under Article 46 of the WHO Constitution), and that consequently the present locations of the WHO regional offices were fixed by resolutions of the Executive Board.

As regards the question, now under consideration, of relocating the Regional Office for the Eastern Mediterranean, the Group recalls that the Health Assembly, by its decision of 25 May 1979, called for the adoption of "such a decision by the Health Assembly".

3. Coordination with the United Nations and interested specialized agencies

It should be kept in mind that the Organization has always consulted with the United Nations, through the Administrative Committee on Coordination (ACC), on the location of any of its regional offices, under Article XI (2) of the Agreement between the United Nations and the World Health Organization, which reads as follows:

Any regional or branch offices which the World Health Organization may establish shall, so far as practicable, be closely associated with such regional or branch offices as the United Nations may establish.

The need for consultation has also been underlined in paragraph 22 of the Annex to United Nations General Assembly resolution 32/197 of 20 December 1977, which reads:

Subject to such guidance as may be provided by the Governments concerned and without prejudice to membership of the regional bodies concerned, the organizations of the United Nations system should take early steps to achieve a common definition of regions and subregions and the identical location of regional and subregional offices.

Similarly, the relationship agreement concluded by WHO with FAO provides that these agencies "agree to keep each other informed of plans for the initial establishment and relocation of regional and branch offices and to consult together with a view, where

1 See WHO Official Records, No. 13, 1948, p. 344; see also resolution WHA1.72.
3 See also Repertory of practice of United Nations organs, Vol. III, Article 63, paragraph 182: "With regard to regional offices, consultation has taken place from time to time within the framework of ACC, both with regard to the location of such offices and in connexion with the coordination or pooling of administrative services among the regional or branch offices grouped in the same locality".
practicable, to entering into co-operative arrangements as to location, staffing and the use of common services”. A similar provision appears in WHO’s agreement with UNESCO.¹

UNESCO and ICAO, as well as FAO, have established the following regional offices located in Egypt:

- the UNESCO Regional Office for Science and Technology in the Arab States, with about 25 staff members now serving in Cairo;

- the ICAO Middle East and Eastern African Office in Cairo, with a total staff of 27;

- the FAO Regional Office for the Near East in Cairo, with 27 internationally recruited staff members and 65 local general service staff members.²

It may be noted nevertheless that the FAO Conference has recently decided to close the FAO Office.³

The United Nations Economic Commission for Western Asia (ECWA), which is the principal United Nations organ for the region concerned, has recently established its offices in Baghdad after having worked for many years in Beirut.⁴

Beirut continues to be the seat of branch offices of UNICEF, UNHCR, UNESCO and UNRWA. UNEP maintains an office in Bahrain.

4. Question of denunciation of the existing Host Agreement ⁵

4.1 Introduction

At the Thirty-second World Health Assembly, the delegate of Egypt raised the issue of the applicability of Section 37 of the Agreement of 25 March 1951 between WHO and Egypt to the question of a transfer of the Regional Office for the Eastern Mediterranean.⁶ This section reads as follows:

The present Agreement may be revised at the request of either party. In this event the two parties shall consult each other concerning the modifications to be made in its provisions. If the negotiations do not result in an understanding within one year, the present Agreement may be denounced by either party giving two years' notice.

The basic rules of interpretation of this and of any other treaty are laid down in Articles 31 and 32 of the Vienna Convention on the Law of Treaties, done on 23 May 1969, which refer inter alia to the preparatory work and any subsequent practice in the application of a treaty.

³ See draft resolution C79/LIM/46 of 23 November 1979, which was adopted by consensus (see document C79/III/PV/5).
⁴ On the move and its cost implications, see United Nations document A/34/7 Add.5.
⁵ Reproduced in part 5(b), pp. 68-78.
⁶ See summary record of the fourteenth meeting of Committee B held on 24 May 1979 (document WHA32/1979/REC/3, p. 403).
4.2 Historical background

Tracing the historical origin of the clause appearing in Section 37 of the Agreement between WHO and Egypt of 1951, commonly called, and cited below as, the "Host Agreement", one finds that this clause corresponds to Article 29 of the Headquarters Agreement concluded in 1948-1949 between WHO and the Swiss Government, which served as the model for the Host Agreement. It must be added that the host agreements for the other regional offices of the Organization similarly incorporate the clause first introduced by WHO in its Headquarters Agreement and that consequently this clause would have to be interpreted in the same manner for the Headquarters Agreement and all of the host agreements for regional offices.

The WHO Headquarters Agreement of 1948-1949 in turn was modelled on an earlier treaty, i.e. the Agreement of 11 March 1946 between the Swiss Federal Council and the International Labour Organisation concerning the legal status of the International Labour Organisation in Switzerland (hereinafter referred to as the "ILO Headquarters Agreement"). The preparatory work for the two headquarters agreements (ILO and WHO) does not shed any direct light on the meaning of the renegotiation and denunciation clause here under consideration. However, it is interesting to note that the ILO Headquarters Agreement was negotiated after ILO had removed the major part of its office from Switzerland during the war and when it decided after the war to eliminate from its Constitution the provision specifically mentioning Geneva as the seat of the International Labour Office.

4.3 Host Agreement with Egypt

There is no specific comment on Section 37 in the preparatory work on the Host Agreement concluded by WHO with Egypt in March 1951 after approval by the Third World Health Assembly. However, contrary to the Headquarters Agreement with Switzerland, which does not specify the location of the WHO headquarters, the Agreement with Egypt mentions expressly, in Section 1(v), the location of "the Regional Office in Alexandria".

In the absence of any indication in the preparatory work for Section 37 of the Host Agreement which could help in its interpretation, subsequent practice with regard to the application of this and other analogous agreements would be particularly important. However, no case has ever occurred in WHO or in ILO in which the renegotiation and denunciation clauses of the respective headquarters and host agreements have had to be put to a practical test. In November 1978 the question of the relocation of WHO headquarters was raised in the Programme Committee of the Executive Board. At that time, the Director-General, speaking of the political, structural and functional implications, also mentioned legal requirements that might arise under the existing Headquarters Agreement. However, no discussion in depth took place.

The Group considered that it was not in a position to decide whether or not Section 37 of the Agreement with Egypt is applicable. The final position of the Organization on the possible discrepancies of views will have to be decided upon by the Health Assembly. Should the opinion of the Assembly not be agreeable to the Government of Egypt, it would be possible to have this question submitted to arbitration under Section 34 of the Host Agreement; the International Court of Justice could also possibly be requested to provide an advisory opinion under Article 76 of the WHO Constitution.

3 The same clause is also to be found in the host agreement concluded between ICAO and the Government of Egypt on 27 August 1953.
4 See document WHO IC/W.4 of 15 October 1946, p. 3.
6 Resolution WHA3.83; see also other resolutions of the Health Assembly and Executive Board reproduced in the WHO Handbook of Resolutions and Decisions, Vol. I, 1973, p. 357.
7 See document EB65/1980/REC/1, Annex 10, and particularly section 5.2.
5. Denunciation of leases

5.1 For the Regional Office building

The plot of land with an area of 2028 m² and the Regional Office building thereon (net space 2830 m²) in Alexandria have been leased to WHO by the Egyptian Government since 1 July 1949 against a nominal rent of £E 0.100 per annum.

The first lease was concluded for a period of nine years, from 1 July 1949 to 1 July 1958. A second lease was concluded on 15 September 1957 for a further period of nine years, from 1 July 1958 to 1 July 1967. The second lease was however superseded by a new lease agreement signed on 29 May 1958 for a period of 20 years, from 1 July 1958 to 1 July 1978.

By letter of 14 March 1972, the Minister of Health agreed to a further extension of the lease for a period of 15 years, covering the period 1 July 1978 to 1 July 1993. No formal new lease agreement, as for the previous extensions, has so far been signed for the last extension of the lease. The matter is pending with the Egyptian Government for the completion of certain government formalities. Actually, it is understood that the Government has initiated certain internal procedures for having the lease extended to 30 June 1997 instead of 1 July 1993.

While neither the last formal lease agreement covering the period 1 July 1958 - 1 July 1978, nor the previous leases, contained a clause on the denunciation of the lease during its normal duration, this question is covered by an exchange of letters between the Regional Director for the Eastern Mediterranean and the Minister of Health of 30 and 31 May 1958 providing for the following:

"... should the World Health Organization no longer desire to retain the premises, referred to in the above mentioned Renewal of Lease, as the site of its Regional Office, the Organization may, notwithstanding the provisions of clause 3 of the said Renewal of Lease, at any time either terminate this Renewal of Lease by giving three months' notice in writing to the Government or, subject to the approval of the Government, assign this Renewal of Lease to the United Nations or to any of its specialized agencies of which the Government is a Member".

5.2 For staff accommodation

WHO professional staff in Alexandria normally live in privately-rented furnished accommodation. Leases are mostly negotiated on a year-to-year basis and as a rule contain a diplomatic clause allowing the tenant to denounce the lease with one to three months' notice if he or she should be transferred from Alexandria. There may be some staff members whose leases do not contain a diplomatic clause but who in all likelihood would not find it difficult to terminate their leases prematurely due to the great demand for accommodation in Alexandria.

6. Termination of staff contracts

It is expected that most of the professional staff in Alexandria would be offered and would accept reassignment to the new site of the Regional Office, if the move were decided. Many of the general service staff would probably not be able to accept reassignment to the new location of the Regional Office even if such a reassignment were offered, as was done by the United Nations in the case of the transfer of ECWA from Beirut to Baghdad.  

For the termination of existing staff contracts, a notice period of three months would normally apply. Termination indemnities and other entitlements of general service staff who would not be transferred to the new location would be of the order of US$ 350 000-5 400 000. (About 63% of the present general service staff will have completed 10 or more years of service with WHO and would therefore be eligible for termination indemnities or end-of-service grants equivalent to 9.5 to 12 months' salary.)

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1 See United Nations document A/34/7 Add.5, para. 4(b).
In addition to the aforementioned expenditure for the termination of staff contracts, it is to be expected that at least for several months staff expenditures would be incurred simultaneously at the old and the new site of the office.

7. Transitional difficulties for operations

In addition to the conclusion of a host agreement, there are a number of essential requirements which need to be met in order for the Regional Office to be in a position to operate at a new site, particularly with respect to office accommodation and the transfer and recruitment of staff. There would undoubtedly be important repercussions on the work of the Regional Office for some time before, during and after the move. Over the 30 years that the Regional Office has been operating in Alexandria, the Organization has built up a well-trained, experienced, loyal and dedicated general service staff whose cumulative knowledge and experience cannot be replaced in a short time. This is even more the case given the general shortage of qualified secretarial and clerical staff with the required linguistic skills in most countries of the Region.

Should a definite decision concerning the transfer of the Regional Office to another country be taken, some disruption of the work of the Regional Office is likely to arise in the interim period because of staff resignations and other reasons. This could have a serious effect on the implementation of the ongoing technical cooperation programme.

V. QUESTIONS RELATING TO THE CHOICE OF A NEW LOCATION FOR THE REGIONAL OFFICE

1. Introduction

Without intending to prejudge in any way the Assembly's decision as to whether the Regional Office is to be relocated, the Group has examined the conditions and facilities at the alternative locations proposed by the governments in the Region which have offered to act as host to the Regional Office in the event of its transfer. The full information gathered by the Group during the visits to the countries concerned is reproduced in Annexes 3 and 4. The following section summarizes the most essential points, relating in particular to the availability and cost, if any, of appropriate premises, recruitment possibilities for general service staff with the necessary qualifications including language ability, and satisfactory transportation and communication facilities.

While the information gathered during the visits may permit the choice by the Executive Board of a location which appears most suitable, from the operational and financial point of view, it must be kept in mind that the answers to the questions contained in the check-list appearing in Annex 4 reflect essentially the information provided by the interested government authorities and that the members of the Group were not in a position, during their relatively short visits to the potential host countries, to examine in depth all the requirements for the establishment of the Regional Office in the countries concerned.

2. Summary of findings of the Working Group with respect to the potential new host countries

(i) Bahrain

In the event of a transfer of EMRO, the Government undertakes to construct to WHO specifications an office building of the size required, i.e. approximately 4200 m². The new building would be free of charge to WHO and available within 12 to 18 months. In the meantime, suitable temporary accommodation would be available immediately at notional rent.

General service staff with a knowledge of Arabic and English can be easily found locally but there is some uncertainty about the local availability of staff with French language capabilities.

Transportation and communication facilities are good.

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1 Not reproduced in this volume.

2 The findings with respect to Cyprus were contained in a separate report of the Working Group (see section (b), p. 59).
(ii) **Iran**

The Government intends to make available, free of charge, a suitably located building now under construction which could be adapted to WHO requirements within six to 12 months. The gross space of the building, including garage facilities, is 8975 m$^2$, whereas the net office space of the building of approximately 2800 m$^2$ corresponds to the net space available at the present EMRO premises but remains below the desired size of 4200 m$^2$ of net space.

General service staff with English and French language capabilities are at present easily available, but staff fluent in Arabic can be found only with difficulty.

Communications are generally satisfactory. As regards general conditions, government officials were hopeful that after completion of the present political changes, these conditions would be conducive to the satisfactory and efficient operation of the Regional Office.

(iii) **Iraq**

The Government has offered to make available, free of charge, a building which could be adapted to WHO needs within six months and which meets the space requirements, except as regards conference rooms. The Government would also place all other necessary facilities at the disposal of WHO, including reconstruction of the building to provide a conference room for sessions of the Regional Committee, if so desired.

Local recruitment of general service staff and temporary staff proficient in French may cause problems.

The Government has indicated that, even if Baghdad is not selected, it is fully prepared to support the establishment and subsequent running of the office in any other Arab State. Reference was made to the Government's generous support for the relocation of the United Nations Economic Commission for Western Asia (ECWA) from Beirut to Baghdad.

Communication and transport facilities are adequate.

(iv) **Jordan**

The Government suggests that the Organization rent the required office space at a cost of some US$ 700 000 per annum in a large commercial centre at present under construction;¹ the part of the building chosen by WHO could be adapted to its needs within six months. Alternative accommodation, probably at lower rent, appears to be available in two or more smaller buildings near to each other which together could meet the space requirements. In the light of the high rental expenses, construction of a building by WHO itself should be given serious consideration in case of a move to Amman. The Government offers a one-time payment of US$ 1 million towards the transfer and start-up of the Regional Office.

Initial recruitment difficulties are likely to occur for general service staff. Staff with French language skills and temporary staff are difficult to find.

Communications and transportation facilities are generally satisfactory, although entry ports are rather distant.

(v) **Kuwait**

The Government is prepared to match existing facilities in Alexandria (i.e., to provide, within six months, a building of 2830 m$^2$) at token rent.

Local recruitment of general service staff might cause some difficulties but this could be overcome by recruitment from other countries in the Region. The Government would consider some rental subsidy for general service staff provided other countries in the Region gave financial support.

Communication and transportation facilities are good.

¹ See, however, the communication dated 17 March 1980 from the Government of Jordan (p. 62).
(vi) **Lebanon**

The Government offers to make available to WHO, free of charge, the building previously occupied by ECWA. This building could be adapted to WHO requirements, in particular by the creation of a conference room.

General service staff with the requisite language skills can be easily found locally.

Communication and transport facilities are good. One significant uncertainty is local security. Government officials are reassuring in this regard and report a steady improvement in the situation.

(vii) **Libyan Arab Jamahiriya**

The proposed location for the Regional Office is Benghazi. As a long-term solution the Government is willing to construct a building in accordance with WHO's requirements, which would be expected to be completed within 18 to 24 months. In the meantime the Government offers, at WHO's choice, one of several buildings at present under construction which could be adapted to WHO requirements, except as regards conference rooms and storage and other areas. There would be a token rental of one Libyan dinar per annum.

With regard to general service staff, nationals are not available. Dependents of expatriates with a knowledge of English or French besides their mother tongue may be available to a certain extent.

The housing situation is difficult. The Government stated however that an apartment building could be made available for the professional staff.

Communications and transportation facilities suffer somewhat from the fact that Benghazi airport is served only by a limited number of airlines.

(viii) **Pakistan**

While the Government initially wished to have both Islamabad and Karachi considered as possible sites for the Regional Office, it has, in a letter dated 7 October 1979, submitted after the visit of members of the Working Group, recommended Islamabad as the possible location of the Regional Office. According to this letter the Government would initially provide temporary office space at Islamabad in a rented building (not yet specified) that could be made available in about six to 12 months. Later it is contemplated to construct a separate building for WHO, the cost of which would also be borne by the Government. The Government estimates that the new building, which it hopes to hire on the estate of the National Health Laboratories in Islamabad, would be available in two to three years.

The Government feels that general service staff speaking English and Arabic or English and French can be found locally.

Communications and transportation facilities are adequate although the distance from Islamabad to the nearest port in Karachi is 1600 kilometres and although air connexions to Islamabad itself are not yet fully developed.

(ix) **Syrian Arab Republic**

The Government offers to construct a building in accordance with WHO's requirements with a floor space of around 4800 m$^2$, on a plot of land of 6249 m$^2$, affording room also for parking lots, etc. The building could be completed two years after the Organization submits its detailed requirements. In the meantime, the Government offers to make available, as temporary accommodation for the Regional Office, the former embassy of the USSR and a hotel building situated at 4 km distance from each other. Premises would be made available at a token rental.

General service and temporary staff can be found locally.

Communications and transportation facilities are adequate.
3. Estimated costs resulting from a transfer of the Regional Office

The table\(^1\) in the Addendum to this report gives the estimated costs, under local conditions, for each of the ten countries which have offered to host the Regional Office. The costs shown in section 1 are recurring costs, while those in section 2 are "one-time" non-recurring costs.

3.1 Professional staff

The various entitlements listed under this heading are based on the Staff Rules, as follows:
- Post adjustment: Staff Rule 335
- Installation allowance: Staff Rule 365
- Reassignment travel costs: Staff Rules 800 to 899
- Shipping of personal effects: Staff Rule 850

These allowances and entitlements vary from time to time and from country to country. The figures shown in the table\(^1\) in the Addendum reflect the levels pertaining at the time of its preparation and are thus indicative only.

3.2 General service staff

The salaries and allowances shown are based on the established United Nations levels in each country. These figures are in turn based on the number and grade of the general service posts established in the Regional Office. The salaries and allowances vary from time to time and from country to country and are thus indicative only.

3.3 Common services

The figures shown against this heading are estimates. They relate to common services such as electricity, water, postage, cables, telex and telephones.

3.4 Rental of space

According to the reports of the visits of the Working Group to nine potential host countries the Government of Jordan has indicated that it would be unable to bear the cost of the rental of the requisite space for the Regional Office.\(^2\) The estimated sum has therefore been shown under this cost element in the column "Jordan" in the table\(^1\) in the Addendum.

3.5 Shipment of capital assets, files and archives

The figures shown against this heading are estimates according to the shipping rates prevailing at the time of the preparation of the table\(^1\) in the Addendum.

3.6 Furniture and equipment

It is estimated that it will be necessary to purchase some furniture and equipment to replace some of that which, because of its condition, would be uneconomical to transport to a new location from Alexandria. A lump sum has therefore been included under this heading for this purpose.

3.7 Contingency

It is deemed prudent to budget for additional requirements which cannot at this stage be foreseen. A conservative figure of 8% has been used for this purpose.

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\(^1\) See pp. 60-61.
\(^2\) See, however, the communication dated 17 March 1980 from the Government of Jordan (p. 62).
4. **Legal requirements (privileges and immunities)**

While the privileges and immunities granted by Member States in general are laid down in the Convention on the Privileges and Immunities of the Specialized Agencies and in its Annex VII relating to WHO, it has been the practice of WHO and of other organizations of the United Nations system to conclude more detailed host agreements with any country chosen as a seat for regional offices. The host agreements for the WHO regional offices were all approved by the World Health Assembly and follow a common pattern.

All potential host countries so far visited have indicated their willingness to conclude a host agreement with WHO similar to the agreement with the present host country. To facilitate official travel to the Regional Office it would also be desirable that the future host country should allow holders of United Nations laissez-passer to enter without requiring visas. Bahrain, Lebanon and Pakistan have agreed to do so by general notification to the United Nations.

(b) **Addendum to the report of the Working Group**

1. **Introduction**

Following the visit to Cyprus carried out from 10 to 13 January 1980 by two of its members, the Working Group on the Question of a Transfer of the Regional Office for the Eastern Mediterranean (EMRO) reconvened on 14 January 1980 in order to establish its findings with regard to this country’s offer to act as host to the Regional Office and in order to supplement accordingly the report adopted on 7 and 8 January 1980 with regard to the nine potential host countries previously visited.

2. **Summary of findings of the Working Group with respect to Cyprus**

On the basis of the report on the visit to Cyprus, the Group reached the following findings.

If a transfer of the Regional Office is decided, the Government would intend to construct a building meeting WHO’s requirements and to put it at the Organization’s disposal at a nominal rent; the Government estimates that this new building would be available in 18 to 24 months. In the meantime, temporary accommodation of adequate size (except for conference rooms in the same building) is guaranteed.

While general service staff can be easily found locally, there is some problem concerning the recruitment of staff fluent in Arabic. However, government officials seemed confident that such staff could be recruited as banks and airlines are able to do so.

Communications and transport facilities are good.

3. **Costs resulting from a transfer of the Regional Office**

One-time and recurring costs resulting from a possible transfer of the Regional Office are shown with respect to Cyprus as well as the other potential host countries in the following table.
**Estimated Costs for the Regional Office in Ten Potential Host Countries**


(Based on 1980-1981 budget for Alexandria and on data available at 1 January 1980 for other locations, in US dollars)

<table>
<thead>
<tr>
<th>Location</th>
<th>Alexandria</th>
<th>Bahrain</th>
<th>Cyprus</th>
<th>Iran</th>
<th>Iraq</th>
<th>Jordan</th>
<th>Kuwait</th>
<th>Lebanon</th>
<th>Libyan Arab Jamahiriya</th>
<th>Pakistan</th>
<th>Syrian Arab Republic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Recurring costs (annual)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Professional staff</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Salaries and allowances</td>
<td>1,750,000</td>
<td>1,750,000</td>
<td>1,750,000</td>
<td>1,750,000</td>
<td>1,750,000</td>
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<td>1,750,000</td>
<td>1,750,000</td>
<td>1,750,000</td>
</tr>
<tr>
<td>Post adjustment</td>
<td>296,600</td>
<td>1,275,300</td>
<td>278,800</td>
<td>790,900</td>
<td>336,100</td>
<td>790,900</td>
<td>701,900</td>
<td>474,500</td>
<td>1,067,700</td>
<td>336,100</td>
<td>879,800</td>
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</tr>
<tr>
<td>Salaries and allowances</td>
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<td>1,250,600</td>
<td>2,504,000</td>
<td>1,283,700</td>
<td>1,733,100</td>
<td>2,308,200</td>
<td>1,842,000</td>
<td>1,591,200</td>
<td>350,000</td>
<td>1,030,400</td>
</tr>
<tr>
<td>Temporary staff</td>
<td>36,500</td>
<td>36,500</td>
<td>36,500</td>
<td>36,500</td>
<td>36,500</td>
<td>36,500</td>
<td>36,500</td>
<td>36,500</td>
<td>36,500</td>
<td>36,500</td>
<td>36,500</td>
</tr>
<tr>
<td>Common services</td>
<td>335,000</td>
<td>773,000</td>
<td>500,000</td>
<td>723,000</td>
<td>695,000</td>
<td>620,000</td>
<td>741,000</td>
<td>579,000</td>
<td>617,000</td>
<td>335,000</td>
<td>500,000</td>
</tr>
<tr>
<td>Rental of space</td>
<td>700,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Duty travel</td>
<td>103,300</td>
<td>103,300</td>
<td>103,300</td>
<td>103,300</td>
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<tr>
<td>Contingency for unforeseen additional requirements</td>
<td>198,600</td>
<td>43,800</td>
<td>196,100</td>
<td>43,800</td>
<td>182,200</td>
<td>174,700</td>
<td>106,300</td>
<td>136,700</td>
<td></td>
<td></td>
<td>67,500</td>
</tr>
<tr>
<td><strong>Total recurring costs</strong></td>
<td>3,485,000</td>
<td>6,166,300</td>
<td>3,989,200</td>
<td>6,132,000</td>
<td>4,076,000</td>
<td>5,944,200</td>
<td>5,843,800</td>
<td>4,919,800</td>
<td>5,330,600</td>
<td>2,939,100</td>
<td>4,395,700</td>
</tr>
<tr>
<td>Cost in Alexandria</td>
<td>3,485,000</td>
<td>3,485,000</td>
<td>3,485,000</td>
<td>3,485,000</td>
<td>3,485,000</td>
<td>3,485,000</td>
<td>3,485,000</td>
<td>3,485,000</td>
<td>3,485,000</td>
<td>3,485,000</td>
<td>3,485,000</td>
</tr>
<tr>
<td>Increase (decrease) in recurring costs</td>
<td>2,681,300</td>
<td>504,200</td>
<td>2,647,000</td>
<td>591,600</td>
<td>2,659,200</td>
<td>2,358,800</td>
<td>1,424,800</td>
<td>1,865,600</td>
<td>(545,900)</td>
<td></td>
<td>910,700</td>
</tr>
<tr>
<td>Percentage increase (decrease) in recurring costs</td>
<td>76.94%</td>
<td>14.47%</td>
<td>75.95%</td>
<td>16.98%</td>
<td>70.37%</td>
<td>67.68%</td>
<td>61.17%</td>
<td>52.96%</td>
<td>(15.66%)</td>
<td></td>
<td>26.13%</td>
</tr>
</tbody>
</table>
### 2. Nonrecurring costs (first year only)

<table>
<thead>
<tr>
<th></th>
<th>(Egypt)</th>
<th>Alexandria</th>
<th>Bahrain</th>
<th>Cyprus</th>
<th>Iran</th>
<th>Iraq</th>
<th>Jordan</th>
<th>Kuwait</th>
<th>Lebanon</th>
<th>Libyan Arab Jamahiriya</th>
<th>Pakistan</th>
<th>Syrian Arab Republic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Installation allowances</td>
<td></td>
<td></td>
<td>367 300</td>
<td>161 200</td>
<td>251 200</td>
<td>201 900</td>
<td>240 000</td>
<td>393 000</td>
<td>147 000</td>
<td>179 000</td>
<td>193 000</td>
<td>176 000</td>
</tr>
<tr>
<td>Reassignment travel</td>
<td></td>
<td></td>
<td>45 600</td>
<td>28 800</td>
<td>44 300</td>
<td>37 400</td>
<td>28 800</td>
<td>40 400</td>
<td>28 800</td>
<td>61 500</td>
<td>77 800</td>
<td>28 800</td>
</tr>
<tr>
<td>Shipment of personal effects</td>
<td></td>
<td></td>
<td>359 500</td>
<td>303 100</td>
<td>421 400</td>
<td>337 100</td>
<td>305 300</td>
<td>332 000</td>
<td>303 100</td>
<td>428 300</td>
<td>634 700</td>
<td>305 300</td>
</tr>
<tr>
<td>Shipment of capital assets, files and archives</td>
<td></td>
<td></td>
<td>580 300</td>
<td>368 300</td>
<td>792 300</td>
<td>691 600</td>
<td>418 700</td>
<td>548 300</td>
<td>368 300</td>
<td>564 400</td>
<td>859 800</td>
<td>447 800</td>
</tr>
<tr>
<td>Furniture and equipment</td>
<td></td>
<td></td>
<td>200 000</td>
<td>200 000</td>
<td>200 000</td>
<td>200 000</td>
<td>200 000</td>
<td>200 000</td>
<td>200 000</td>
<td>200 000</td>
<td>200 000</td>
<td>200 000</td>
</tr>
<tr>
<td>Contingency for unforeseen additional requirements (8%)</td>
<td></td>
<td></td>
<td>124 300</td>
<td>84 900</td>
<td>136 800</td>
<td>117 000</td>
<td>95 200</td>
<td>121 100</td>
<td>83 800</td>
<td>114 800</td>
<td>141 700</td>
<td>92 100</td>
</tr>
<tr>
<td><strong>Total nonrecurring costs</strong></td>
<td></td>
<td></td>
<td>1 677 000</td>
<td>1 146 300</td>
<td>1 846 000</td>
<td>1 585 000</td>
<td>1 288 000</td>
<td>1 635 000</td>
<td>1 131 000</td>
<td>1 548 000</td>
<td>1 907 000</td>
<td>1 250 000</td>
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</table>

### 3. Total first year estimated cost

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th>3 485 000</th>
<th>7 843 300</th>
<th>5 135 500</th>
<th>7 978 000</th>
<th>5 661 600</th>
<th>7 232 200</th>
<th>7 478 800</th>
<th>6 050 800</th>
<th>6 878 600</th>
<th>4 846 100</th>
<th>5 645 700</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost in Alexandria</td>
<td></td>
<td></td>
<td>3 485 000</td>
<td>3 485 000</td>
<td>3 485 000</td>
<td>3 485 000</td>
<td>3 485 000</td>
<td>3 485 000</td>
<td>3 485 000</td>
<td>3 485 000</td>
<td>3 485 000</td>
<td>3 485 000</td>
<td>3 485 000</td>
</tr>
<tr>
<td>First year increased cost</td>
<td></td>
<td></td>
<td>4 358 300</td>
<td>1 650 500</td>
<td>4 493 000</td>
<td>2 178 600</td>
<td>3 747 200</td>
<td>3 993 800</td>
<td>2 565 800</td>
<td>3 393 600</td>
<td>1 361 100</td>
<td>2 160 700</td>
<td></td>
</tr>
</tbody>
</table>
2. COMMUNICATION RECEIVED BY THE DIRECTOR-GENERAL
FROM THE GOVERNMENT OF JORDAN

(A33/19 Add.1 - 17 April 1980)

Subsequent to the deliberations of the Executive Board, the Director-General has received the following letter dated 17 March 1980 from the Government of Jordan, informing him that the Government would only charge a nominal fee instead of the rent of US$ 700 000 for office space mentioned in the study by the Executive Board. The percentage increase in recurring costs shown for Jordan in the Addendum to the Working Group's report (see preceding table) should consequently read 50.48% instead of 70.57%.

Ministry of Health
The Hashemite Kingdom of Jordan

Dear Sir,

With reference to our letter dated 23 January 1980, submitted by our representative Dr. Aram Yaghlian to the Executive Board of WHO during its meeting in Geneva on 21 January 1980, concerning the transfer of the Regional Office for the Eastern Mediterranean, I have the pleasure to inform you that the Government of the Hashemite Kingdom of Jordan has decided that it would host the Office in Jordan at a nominal fee of one Jordanian dinar per annum.

Yours faithfully,

(signed)

Dr Zuhair Malhas
Minister of Health

Original: Arabic

3. COMMUNICATION RECEIVED BY THE DIRECTOR-GENERAL
FROM THE GOVERNMENT OF THE SYRIAN ARAB REPUBLIC

(A33/19 Add.2 - 5 May 1980)

Subsequent to the deliberations of the Executive Board, the Director-General has received the following letter dated 5 May 1980 from the Government of the Syrian Arab Republic.

Permanent Mission of the Syrian Arab Republic, Geneva

Sir,

I have the honour to inform you that the Government of the Syrian Arab Republic hereby confirms its undertaking to offer every guarantee necessary to ensure the smooth functioning of the headquarters of the Regional Office for the Eastern Mediterranean, such as the privileges and immunities that are accorded to organizations and offices similar to the Regional Office for the Eastern Mediterranean, as well as facilities concerning the movement of experts, transport and telecommunications.

May I ask you to be kind enough to have this letter circulated as an official document of the present session of the World Health Assembly?

I have the honour to be, Sir, your obedient servant,

Original: French

(signed)

Ghasoub Rifai
Minister of Health

1 See part 1 (a), subsection V, 2 (iv), p. 56.
4. REQUEST FROM THE DELEGATION OF SAUDI ARABIA

13 May 1980

At the request of the delegation of Saudi Arabia, the Director-General has the honour to submit the following report to the Thirty-third World Health Assembly for its information.

(a) Letter, dated 13 May 1980, from the Minister of Health, Saudi Arabia, to the Regional Director for the Eastern Mediterranean

13 May 1980

Dear Sir,

I wish to refer to Sub-Committee A of the Special Session of the Regional Committee for the Eastern Mediterranean, which was held in Geneva on 9 May 1980, and to its resolution to transfer the WHO Regional Office to "Amman - Jordan".

On behalf of my colleagues, the Arab Ministers of Health who attended the above meeting, I wish to request the circulation of the report of Sub-Committee A (EM/RC-SSA 2/3), including the Sub-Committee's resolution, in all working languages to all delegations of all Member States attending the Thirty-third World Health Assembly.

Thank you for your cooperation,

(signed)

Dr Hussein Al Gezairy
Minister of Health of Saudi Arabia
and Chief Delegate of Saudi Arabia
to the Thirty-third World Health Assembly
THIRTY-THIRD WORLD HEALTH ASSEMBLY

(b) Report of Sub-Committee A of the second special session of the Regional Committee for the Eastern Mediterranean

REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN

Special Session

SUB-COMMITTEE A

REPORT OF SUB-COMMITTEE A OF THE SPECIAL SESSION OF THE REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN

WHO Building, Geneva, Friday, 9 May 1980, at 9.30 a.m.

I. INTRODUCTION

1. Sub-Committee A of the second special session of the Regional Committee for the Eastern Mediterranean met at the WHO building in Geneva on 9 May 1980. The following Member States were represented:

   Afghanistan  Kuwait  Somalia
   Bahrain      Lebanon  Sudan
   Democratic Yemen  Libyan Arab Jamahiriya  Syrian Arab Republic
   Egypt        Oman      Tunisia
   Iran         Pakistan  United Arab Emirates
   Iraq         Qatar     Yemen
   Jordan       Saudi Arabia

2. All Member States represented exercised their right of vote in Sub-Committee A.

3. The session was also attended by a representative of the League of Arab States and observers from the Palestine Liberation Organization.

II. OPENING OF THE SESSION AND ELECTION OF OFFICERS: Agenda items 1 and 2

4. The session was opened by H.E. Mr K. Al Mana, Minister of Health of Qatar and Chairman of Sub-Committee A of the twenty-ninth session of the Regional Committee for the Eastern Mediterranean, who continued in the Chair for the special session. Dr S. Azzuz (Libyan Arab Jamahiriya) was appointed Rapporteur.

III. TRANSFER OF THE REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN FROM ALEXANDRIA: Agenda item 3

Background

5. Dr A. H. Tabi, Regional Director, said that the special session had been convened in accordance with Rule 6 of the Rules of Procedure to discuss the question of the transfer of the Regional Office for the Eastern Mediterranean from Alexandria. The Sub-Committee had before it three documents submitted to the Thirty-third World Health Assembly: document A33/19, to which was annexed the report of the Working Group appointed by the Executive Board to study the question of a transfer; document A33/19 Add.1, containing a communication from the Government of Jordan informing the Director-General that it would charge only a nominal fee for office space for the Regional Office instead of the US$ 700,000 mentioned in the report of the Board's Working Group; and document A33/19 Add.2, containing a communication from the Government of the Syrian Arab Republic confirming its undertaking to offer all privileges and immunities necessary to ensure the smooth functioning of the Regional Office.
6. Dr Taba recalled that the Working Group had been set up by the Executive Board to undertake the study requested by the Thirty-second World Health Assembly in response to the wish expressed by the majority of Members of Sub-Committee A for the Regional Office to be transferred to another State in the Region.

7. The Working Group had held four meetings, and had visited the Regional Office in Alexandria. Sub-groups had also visited the countries that had offered to act as host to the Regional Office in the event of its transfer. The Working Group had formed a high opinion of the quality of the Regional Office staff, both international and locally recruited.

8. Dr Taba noted that section IV of the Working Group's report outlined a number of legal, operational, financial and technical aspects of a possible relocation. The Working Group had pointed out that the authority for determining the site of the Regional Office lay with the World Health Assembly and that the United Nations should be consulted on the possible relocation of that Office. It had also noted that at the Thirty-second World Health Assembly, the Government of Egypt had raised the question of the applicability of Section 37 of the Host Agreement, which concerned the denunciation of the Agreement. The Working Group had considered that it was not in a position to decide whether or not Section 37 of the Agreement with Egypt was applicable and had noted that the question would have to be decided upon by the Health Assembly. The current lease for the Regional Office in Alexandria could be terminated at three months' notice.

9. The Working Group had been very satisfied with its visits to possible host countries. In its report, it had included estimates of the cost of the transfer to the various countries. One change was necessary in the light of the decision of the Government of Jordan to offer premises at a nominal rent; the increase in recurring costs for that country should be reduced from 70.57% to 50.48%. The Group had also referred to the need to conclude a detailed host agreement with any country chosen as the site for the Regional Office, which should be approved by the Health Assembly. In addition to the tables of initial and recurring costs, the report included a check-list indicating the various facilities available and offered.

General discussion

10. In view of the decision of principle already taken at the special session in May 1979, and the detailed study carried out by the Board's Working Group, a representative proposed that the Sub-Committee should now determine the most suitable alternative site for the Regional Office. The matter could then be transmitted to the Health Assembly for its approval and a host agreement could be signed between WHO and the new host country. As a number of Arab countries had offered to act as host, the Arab group had agreed to facilitate the Sub-Committee's task by nominating one country as host: Jordan. That did not of course exclude candidates from countries outside the Arab group.

11. It was pointed out that in addition to the country nominated by the Arab group, there were other candidates. These were Cyprus, Iran and Pakistan.

12. The representative of Egypt believed that the principles of international and regional cooperation, to which scientific and technical collaboration made an important contribution, were being undermined by the present discussion. Despite many differences of opinion in the past, wisdom had prevailed and the Region's temporary political differences had been overcome. It was essential not to permit temporary political crises to interfere with WHO's technical and humanitarian work. If technical cooperation was constantly interrupted because of political differences, repeated transfers might be required from a series of host countries.

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1 Document EB64/1979/REC/1, p. 4, decision (1).
2 Document WHA32/1979/REC/1, p. 46, decision (19).
13. The following points were also made: (1) Egypt had always supported technical cooperation in the Region; (2) it had abided by, and would continue to abide by, all its commitments as host country and as a member of Sub-Committee A; (3) it believed that the proposal to transfer the Regional Office was a purely political move unrelated to WHO's technical and humanitarian activities; (4) it therefore objected to the proposal, which was without legal basis; (5) it believed that the difficulty could be solved by free discussion without raising it at non-political meetings; (6) it would resist any move that detracted from technical cooperation in health and tended to disperse the experience acquired in this field; and (7) the WHO Constitution and agreements arising under it should be respected.\(^1\)

14. Another representative observed that the Sub-Committee took no pleasure in the discussion or in the political situation that had occasioned it. Egypt was close to the hearts of the other countries of the Region. Moreover, it was recognized that the transfer would cause difficulties. However, the fact remained that the Regional Office could not carry out its technical functions in a country with which other countries had broken off diplomatic relations. Collaboration was impossible in the present circumstances. It was essential to reach an objective decision at the present meeting.

15. A view was also expressed that the question was not purely political. It was also one of principle. Full health was not possible when Israel had launched aggression against the people of Palestine, occupied its territories and deprived it of its homeland. In the past, Egypt had refused to deal with Israel, but now the situation had changed.

16. The representative of Jordan expressed his regret that it was necessary to request the transfer of the Regional Office from the brother country of Egypt. He emphasized that Jordan, if selected, would welcome the Regional Office, and would abide fully by all commitments between WHO and the host country.

17. After a short break for consultations, the representative of the Islamic Republic of Iran withdrew his country's candidature in favour of Jordan.

18. After further discussion, and having requested the views of certain members of the Sub-Committee, the representative of Pakistan similarly withdrew his country's candidature.

Consideration of a resolution

19. The representative of Saudi Arabia read out the text of a draft resolution for the Sub-Committee's consideration. During the subsequent discussion, a third operative paragraph was added.

20. After further discussion, the draft resolution was put to the vote by the Chairman. The result of the vote was as follows: number of countries present and voting, 20; in favour, 19; against, 1. The resolution was therefore adopted.\(^2\)

21. The representative of Egypt expressed his objection to the Sub-Committee's recommendation, which in his delegation's view was based purely on political considerations.

IV. CLOSURE OF THE SESSION

22. The Chairman declared the special session closed.

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\(^1\) See the communication from the delegation of Egypt (p. 80).

\(^2\) Resolution EM/RC-SSA2/R.1 (see p. 67).
RESOLUTION EM/RC-SSA 2/R.1

The Sub-Committee,

Convinced of the need to transfer the WHO Regional Office for the Eastern Mediterranean from Alexandria, Arab Republic of Egypt,

Acknowledging with gratitude the facilities having been offered by the countries which have requested to host the Regional Office in case of its transfer and thanking the present host country for its cooperation,

Having reviewed the detailed and objective information provided in the report of the Working Group established by the Executive Board (document EB65/19 Rev.1),

Thanking the Working Group for this comprehensive study of all the aspects of the question of a transfer of the Regional Office and the Executive Board for its endorsement of this study,

1. DECIDES to transfer the Regional Office for the Eastern Mediterranean to Amman, Jordan as soon as possible;

2. DECIDES to cover through voluntary contributions from the Member States of the Eastern Mediterranean Region the full cost of the transfer of the Regional Office to Amman, and the increased recurring annual costs for a period of five years;

3. REQUESTS the Regional Director to transmit this resolution to the World Health Assembly for its approval.

(Adopted 9 May 1980)

5. REQUEST FROM THE DELEGATION OF EGYPT

At the request of the delegation of Egypt, the Director-General has the honour to distribute to the Thirty-third World Health Assembly for its information the text of the Host Agreement between the Government of Egypt and the World Health Organization.

(a) Letter, dated 15 May 1980, from the delegation of Egypt to the Director-General

Mr Director-General,

Geneva, 15 May 1980

I have the pleasure to request you to distribute the text of the Host Agreement between my Government and the WHO as an information document under item 42 of the Thirty-third World Health Assembly agenda.

With best regards,

(signed)

O. El-Shafei
Ambassador
Deputy Leader of the Egyptian Delegation
No. 3058. AGREEMENT BETWEEN THE WORLD HEALTH ORGANIZATION AND THE GOVERNMENT OF EGYPT FOR THE PURPOSES OF DETERMINING THE PRIVILEGES, IMMUNITIES AND FACILITIES TO BE GRANTED IN EGYPT BY THE GOVERNMENT TO THE ORGANIZATION, TO THE REPRESENTATIVES OF ITS MEMBERS AND TO ITS EXPERTS AND OFFICIALS. SIGNED AT CAIRO, ON 25 MARCH 1951

THE GOVERNMENT OF EGYPT on the one part, and
THE WORLD HEALTH ORGANIZATION on the other,

DESIRING to conclude an agreement for the purpose of determining the privileges, immunities and facilities to be granted by the GOVERNMENT OF EGYPT to the WORLD HEALTH ORGANIZATION, to the representatives of its Members and to its experts and officials in particular with regard to its arrangements in the EASTERN MEDITERRANEAN REGION, and of regulating other related matters;

HAVE AGREED AS FOLLOWS:

Article I

DEFINITIONS

Section 1. In the present Agreement:
(i) The word "Organization" shall mean the World Health Organization;
(ii) For the purposes of Article IV the words "property and assets", "funds, notes, coins and securities" or "assets, income and other property", shall be deemed to include property, assets and funds administered by the Organization under Article 57 of its Constitution and/or in furtherance of its constitutional functions.
(iii) The words "representatives and Members" shall be deemed to include all delegates to the World Health Assembly, all persons designated by Members to serve on the Executive Board of the Organization, all representatives on the

1 Having been approved by the Fourth World Health Assembly in May 1951 and ratified by the Government of Egypt on 8 August 1951, the Agreement came into force on 8 August 1951 in accordance with article XII, section 35.


Regional Committees in the Eastern Mediterranean Region, as well as all delegates, alternates, advisers, technical experts who are members of delegations and secretaries of delegations;

(iv) The word "Member" shall be deemed to include a Member or an Associate Member of the Organization as well as a territory or group of territories which, without being an Associate Member, is represented and participating in the Regional Committee of the Eastern Mediterranean Region of the Organization, in accordance with Article 47 of its constitution;

(v) The words "principal or subsidiary organs" shall be deemed to include the World Health Assembly, the Executive Board, the Regional Committee in the Eastern Mediterranean Region and any of the subdivisions of all these organs as well as the Secretariat and the Regional Office in Alexandria;

(vi) For the purposes of Sections 4, 6, 16 and 17 the words "freedom of meeting" or "meeting of the Organization" shall be deemed to include all institutional meetings of the principal or subsidiary organs of the Organization as well as all conferences or meetings convened by, or under the authority or auspices of, the Organization in Egypt.

**Article II**

**JURIDICAL PERSONALITY**

Section 2. The Organization shall possess juridical personality and legal capacity and, in particular, capacity

(a) to contract;

(b) to acquire and dispose of immovable and movable property; and

(c) to institute legal proceedings.

**Article III**

**FREEDOM OF ACTION**

Section 3. The Organization and its principal or subsidiary organs shall have in Egypt the independence and freedom of action belonging to an international organization according to international practice.

Section 4. The Organization, its principal or subsidiary organs as well as its Members and the representatives of Members in their relations with the Organization, shall enjoy in Egypt absolute freedom of meeting, including freedom of discussion and decision.
Article IV

Property, Funds and Assets

Section 5. The Organization and its property and assets located in Egypt shall enjoy immunity from every form of legal process except in so far as in any particular case this immunity is expressly waived by the Director-General of the Organization, or the Regional Director as his duly authorized representative. It is, however, understood that no waiver of immunity shall extend to any measure of execution.

Section 6. (1) The premises of the Organization in Egypt or any premises in Egypt occupied by the Organization in connexion with a meeting of the Organization shall be inviolable.

(2) Such premises and the property and assets of the Organization in Egypt shall be immune from search, requisition, confiscation, expropriation; and any other form of interference, whether by executive, administrative, judicial or legislative action.

Section 7. The archives of the Organization, and in general all documents belonging to it or held by it in Egypt shall be inviolable.

Section 8. (1) The World Health Organization may receive and hold funds, notes, coins and securities of any kind and may dispose of them freely both within Egypt and in its relations with other countries.

(2) This section shall also apply to Members of the Organization in their relations with the Organization.

Section 9. The Government of Egypt shall provide for the Organization, at the most favourable rate officially recognized, its national currency to the amount required to meet the expenditure of the Organization in Egypt or other parts of the Eastern Mediterranean Region.

Section 10. In exercising its rights under Sections 8 and 9, the Organization shall pay due regard to any representations made by the Government of Egypt in so far as the Organization considers that effect can be given to such representations without detriment to its interests.

Section 11. The Organization, its assets, income and other property shall be:

(a) exempt from all direct and indirect taxes. It is understood, however, that the Organization will not claim exemption from taxes which are, in fact, no more than charges for public utility services;

(b) exempt from customs duties, prohibitions and restrictions on imports and exports in respect of medical supplies, or any other goods or articles imported or exported by the Organization for its official use. It is understood, however, that such medical supplies, goods, or articles imported under such exemption will not
be sold or ceded in Egypt except under conditions agreed with the Government of Egypt;

(c) exempt from customs duties, prohibitions and restrictions on imports and exports in respect of their publications.

Section 12. While the Organization will not, as a general rule, in the case of minor purchases, claim exemption from excise duties and from taxes on the sale of movable and immovable property which form part of the price to be paid, nevertheless, when the Organization is making important purchases for official use of property on which such duties and taxes have been charged or are chargeable, the Government of Egypt shall make appropriate administrative arrangements for the remission or return of the amount of duty or tax.

Article V

Facilities in respect of Communications

Section 13. The Organization shall enjoy in Egypt for its official communications treatment not less favourable than that accorded by the Government of Egypt to any other Government including its diplomatic mission, in the matter of priorities, rates and taxes on mails, cables, telegrams, radiograms, telephotos, telephone and other communications and Press rates for information to the Press and radio.

Section 14. (1) No censorship shall be applied to the duly authenticated official communications of the Organization.

(2) The Organization shall have the right to use codes and to despatch and receive correspondence by courier or in sealed bags, which shall have the same immunities and privileges as diplomatic couriers and bags.

Article VI

Representatives of Members

Section 15. Representatives of Members of the Organization on its principal or subsidiary organs and at conferences or meetings convened by the Organization and who are not of Egyptian nationality, shall, while exercising their functions and during their journeys to and from the place of meeting, enjoy the following privileges and immunities:

(a) Immunity from Personal arrest or detention and from seizure of their personal baggage, and, in respect of words spoken or written and all acts done by them in their official capacity, immunity from legal process of every kind;
(b) Inviolability for all papers and documents;
(c) The right to use codes and despatch or receive papers or correspondence by courier or in sealed bags;
(d) Exemption in respect of themselves and their spouses from immigration restrictions, aliens registration or national service obligations in Egyptian territory;
(e) The same facilities in respect of currency or exchange restrictions as are accorded to representatives of foreign Governments on temporary official missions;
(f) The same immunities and facilities in respect of their personal baggage as are accorded to members of diplomatic missions of comparable rank;
(g) Such other privileges, immunities and facilities not inconsistent with the foregoing as members of diplomatic missions of comparable rank enjoy, except that they shall have no right to claim exemption from customs duties on articles imported (otherwise than as part of their personal baggage) or from indirect taxes or sales taxes.

Section 16. In order to secure for the representatives of Members of the Organization at a meeting of the Organization complete freedom of speech and independence in the discharge of their duties, the immunity from legal process in respect of words spoken or written and all acts done by them in discharging their duties shall continue to be accorded, notwithstanding that the persons concerned are no longer engaged in the discharge of such duties.

Section 17. If the incidence of any form of taxation depends upon residence in Egypt, periods during which the representatives of Members of the Organization are present at a meeting of the Organization in Egypt for the discharge of their duties shall not be considered as periods of residence.

Section 18. Privileges and immunities are accorded to the representatives of Members of the Organization not for the personal benefit of the individuals themselves, but in order to safeguard the independent exercise of their functions in connexion with the Organization. Consequently, a Member not only has the right, but is under a duty to waive the immunity of its representatives in any case where, in the opinion of the Member, the immunity would impede the course of justice, and it can be waived without prejudice to the purpose for which the immunity is accorded. In any such case in which one of the persons designated to serve on it is concerned, the Executive Board of the Organization shall be under the same duty.

Section 19. The Organization will as far as possible communicate in advance to the Government of Egypt a list of the representatives invited to its conferences or meetings.
Article VII

Experts on Missions for the Organization

Section 20. Experts and consultants other than those who under Section I (iii) or as officials come within the scope of Article VI or VIII respectively and who perform missions for the Organization shall be accorded such privileges and immunities as are necessary for the independent exercise of their functions during the period of their missions, including the time spent on journeys in connexion with their missions. In particular, they shall be accorded:

(a) Immunity from personal arrest or detention and from seizure of their personal baggage and in respect of words spoken or written and acts done by them in the course of the performance of their mission, immunity from legal process of every kind. This immunity from legal process shall continue to be accorded notwithstanding that the persons concerned are no longer employed on missions for the Organization;

(b) Inviolability for all papers and documents;

(c) For the purpose of their communications with the Organization, the right to use codes and to despatch or receive papers or correspondence by courier or in sealed bags;

(d) Exemption in respect of themselves and their spouses from immigration restrictions, aliens' registration or national service obligations in Egypt;

(e) The same facilities in respect of currency or exchange restrictions as are accorded to representatives of foreign governments on temporary official missions;

(f) The same immunities and facilities in respect of their personal baggage as are accorded to members of diplomatic missions.

Section 21. Privileges and immunities are granted to experts in the interests of the Organization and not for the personal benefit of the individuals themselves. The Director-General shall have the right and the duty to waive the immunity of any expert in any case where, in his opinion, the immunity would impede the course of justice and can be waived without prejudice to the interests of the Organization.

Article VIII

Officials

Section 22. The Director-General or the Regional Director as his duly authorized representative, shall from time to time communicate to the Government of Egypt the categories and the names of those officials to whom the provisions of this Article and Article IX shall apply.
Section 23. (1) Officials of the Organization irrespective of nationality shall:

(a) be immune from legal process in respect of words spoken or written and all acts performed by them in their official capacity;

(b) be exempt from taxation in respect of the salaries and emoluments paid to them by the Organization.

(2) Moreover those who are not of Egyptian nationality shall:

(a) be immune, together with their spouses and relatives dependent on them, from immigration restrictions and aliens' registration;

(b) be accorded the same privileges in respect of exchange facilities as are accorded to officials of comparable rank of diplomatic missions to Egypt;

(c) be given, together with their spouses and relatives dependent on them, the same repatriation facilities in time of international crises as officials of comparable rank of diplomatic missions;

(d) have the right to import free of duty their furniture and effects at the time of taking up their post in Egypt or upon their permanent appointment to it;

(e) once every three years have the right to import free of duty a motor-car, it being understood that the duty will become payable in the event of the sale or disposal of such motor-car to a person not entitled to this exemption within three years upon its importation.

Section 24. (1) The officials of the Organization shall be exempt from national service obligations in Egypt provided that, in relation to officials who are Egyptian nationals, such exemption shall be confined to officials whose names have, by reason of their duties, been placed upon a list compiled by the Director-General or the Regional Director as his duly authorized representative and approved by the Government of Egypt.

(2) Should other officials of the Organization be called up for national service, the Government of Egypt shall, at the request of the Director-General or the Regional Director as his duly authorized representative, grant as far as possible such deferrals in the call-up of such officials as may be necessary to avoid serious dislocation in the continuation of essential work.

Section 25. In addition to the immunities and privileges specified in section 22, the Director-General, the Deputy Director-General, the Assistant Directors-General, the Regional Director in Egypt and his Deputy shall be accorded in respect
of themselves, their spouses and minor children, the privileges and immunities, 
exemptions and facilities accorded to diplomatic envoys in accordance with 
international law and usage.

Section 26. Privileges and immunities are granted to officials in the interests 
of the Organization and not for the personal benefit of the individuals themselves. 
The Director-General shall have the right and the duty to waive the immunity of 
any official in any case where, in his opinion, the immunity would impede the 
course of justice and can be waived without prejudice to the interests of the 
Organization.

Article IX

Visas, Permits of Residence, United Nations 
Laissez-Passer and Other Facilities

Section 27. (1) The Government of Egypt shall take all measures required 
to facilitate the entry into, residence in, and departure from Egypt of all persons 
having official business with the Organization, i.e.: 

(a) representatives of Members, whatever may be the relations between 
Egypt and the Member concerned; 
(b) experts and consultants on missions for the Organization irrespective 
of nationality; 
(c) officials of the Organization; 
(d) other persons, irrespective of nationality, summoned by the Organiza-
tion.

(2) Any police regulation calculated to restrict the entry of aliens into Egypt 
or to regulate the conditions of their residence shall not apply to the persons pro-
vided for in this section.

(3) The Government of Egypt shall issue to the embassies, legations and 
consulates abroad general instructions in advance to grant visas to any applicant 
on production of a valid passport or any equivalent identity and travel document 
and of a document establishing his official relationship to the Organization without 
any delay or waiting period and without requiring his personal attendance or the 
payment of any charges.

(4) The provisions of this Section shall apply to the spouse and dependents of 
the person concerned if they live with him and do not exercise an independent 
profession or calling.

Section 28. The Government of Egypt shall recognize and accept as valid 
travel documents the United Nations Laissez-passer issued to the officials of the 
Organization under administrative arrangements concluded between the Director-
General of the Organization and the Secretary-General of the United Nations.
Section 29. The Director-General, the Deputy Director-General, the Assistant Directors-General, the Regional Director of the Organization in Egypt, and the Directors of the Organization travelling on its official business shall be granted the same facilities as are accorded to diplomatic envoys.

Section 30. (1) The Organization will be supplied, in the premises placed at its disposal, with electricity, water and gas, and with service for the removal of refuse. In a case of force majeure entailing partial or total suspension of these services, the requirements of the Organization will be considered by the Government of Egypt to be of the same importance as those of its own administrations.

(2) The Government of Egypt will ensure the necessary police supervision for the protection of the seat of the Organization and for the maintenance of order in the immediate vicinity thereof. At the request of the Director-General, the Government of Egypt will supply such police force as may be necessary to maintain order within the building.

Article X

Security of the Government of Egypt

Section 31. (1) Nothing in the present agreement shall affect the right of the Egyptian Government to take the precautions necessary for the security of Egypt.

(2) If the Egyptian Government considers it necessary to apply the first paragraph of this article, it shall approach the World Health Organization as rapidly as circumstances allow in order to determine by mutual agreement the measures necessary to protect the interests of the World Health Organization.

(3) The World Health Organization shall collaborate with the Egyptian authorities to avoid any prejudice to the security of Egypt resulting from its activity.

Article XI

Co-operation and Settlement of Disputes

Section 32. The Organization shall co-operate at all times with the appropriate authorities of the Government of Egypt to facilitate the proper administration of Justice, secure the observance of police regulations and prevent the occurrence of any abuse in connexion with the privileges, immunities and facilities provided for under the present Agreement.

Section 33. The Organization shall make provision for appropriate modes of settlement of:

(a) disputes arising out of contracts or other disputes of a private law character to which the Organization is a party;
(b) disputes involving any official of the Organization who, by reason of his official position, enjoys immunity, if immunity has not been waived by the Director-General in accordance with the provisions of Section 26.

Section 34. Any difference between the Organization and the Egyptian Government arising out of the interpretation or application of the present Agreement or of any supplementary arrangement or agreement which is not settled by negotiation shall be submitted for decision to a Board of three arbitrators; the first to be appointed by the Egyptian Government, the second by the Director-General of the Organization, and the third, the presiding arbitrator, by the President of the International Court of Justice, unless in any specific case the parties hereto agree to resort to a different mode of settlement.

Article XII

Final Provisions

Section 35. The present Agreement shall enter into force as soon as it has been ratified by the Government of Egypt in accordance with its constitutional procedure and adopted by the World Health Assembly.

Section 36. On the coming-into-force of the present Agreement it will be communicated for registration to the Secretary-General of the United Nations by the Director-General of the Organization, in pursuance of Article 1 of the Regulations, to give effect to Article 102 of the Charter of the United Nations adopted by the General Assembly of the United Nations on 14 December 1946.

Section 37. The present Agreement may be revised at the request of either party. In this event the two parties shall consult each other concerning the modifications to be made in its provisions. If the negotiations do not result in an understanding within one year, the present Agreement may be denounced by either party giving two years' notice.

In faith whereof the present Agreement was done and signed at Cairo on the 25th day of March, 1951, in six copies, three in French and three in English, the texts, in both languages being equally authentic, of which two texts, one copy in French and one in English, were handed to the representatives of the Government of Egypt, and the four remaining copies to the Director-General of the World Health Organization.

For the World Health Organization:

(Signed) A.T. CHOUCHE PACHA

For the Government of Egypt:

(Signed) MOHAMED SALAH EL-DINE
EXCHANGE OF LETTERS

I

Letter from the Egyptian Government to the World Health Organization, dated 25 March 1951

Sir,

With respect to the conclusion between the Egyptian Government and the World Health Organization of the Agreement concerning the privileges, immunities and facilities to be accorded to the Organization in Egypt, I have the honour to submit the following:

1. The Organization may, under Section 8, hold gold and, through normal channels, receive and transfer it to and from Egypt. It shall not, however, transfer from Egypt, more gold than it has brought in.

2. With reference to Article 8, the Organization and the Government shall determine by mutual agreement the categories of officials and the nature and extent of facilities, privileges and immunities to be accorded, to each category.

3. With reference to Section 25, the Organization will not claim on behalf of officials assigned to the staff of the Regional Office in Egypt, who are Egyptian Nationals, irrespective of grade, immunity from the criminal jurisdiction of the Egyptian Courts in respect of words spoken or written and acts performed by them in so far as these words or acts are not spoken or written or performed by them in their official capacity.

4. In claiming the benefit of Section 27 (2) of the Agreement, the Organization will not claim on behalf of the persons mentioned in Section 27 (1) exemption from Police regulations in so far as such regulations are made by virtue of the International Sanitary Conventions or by virtue of similar conventions, agreements or regulations adopted by the World Health Organization.

(Signed) MOHAMED SALAH EL-DINE

II

Letter from the World Health Organization to the Egyptian Government, dated 25 March 1951

Sir,

With respect to the conclusion between the Egyptian Government and the World Health Organization of the Agreement concerning the privileges, immunities and facilities to be accorded to the Organization in Egypt, and in answer to your letter of 25th March, 1951, I have the honour to communicate the following:

1. I agree that...

(See paragraphs 1 to 4 of letter I)

(Signed) A. T. CHOUCHA PACHA
6. RESOLUTION OF SUB-COMMITTEE B OF THE SECOND SPECIAL SESSION OF THE REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN

The Director-General has the honour to submit the following document to the Thirty-third World Health Assembly for its information.

REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN
Special Session 2
SUB-COMMITTEE B
Geneva, 14 May 1980

RESOLUTION

The Sub-Committee,

Having considered the subject of "Transfer of the Regional Office for the Eastern Mediterranean from Alexandria";

Reaffirming the principle that resolutions of the WHO organs should be based on health considerations and not politically motivated;

Stressing the need to guarantee free access to the Regional Office for all members of the region,

1. OPPOSES the proposal to transfer the Regional Office for the Eastern Mediterranean from Alexandria to another location;

2. REQUESTS the Regional Director to transmit this resolution to the World Health Assembly.
7. COMMUNICATION RECEIVED BY THE DIRECTOR-GENERAL
FROM THE DELEGATION OF EGYPT

At the request of the delegation of Egypt, the Director-General has the honour to submit the following communication to the Thirty-third World Health Assembly for its information.

Ministry of Health
Cairo
Egypt

Dear Sir,

[Reproduction of the Minister's letter]

I refer to the report on the above meeting held in Geneva on 9 May 1980.

I wish to bring to your kind attention that the delegation of Egypt considers that paragraph 13, item (5) of the above report does not exactly reflect the statement made by the representative of Egypt, but that it should read as follows:

"It believed that the political differences could be solved through quiet and objective dialogue, and such differences should not be imposed on meetings of a technical character".

Furthermore, paragraph 13, item (6) should read:

"It would reject any move .. .".

Kindly also note that, in the list of representatives attending the above meeting, the title of Mr Fawzi El-Ibrashi should read "Minister Plenipotentiary" in lieu of "Chargé d'affaires".

The above is transmitted to you for necessary circulation during the Thirty-third World Health Assembly.

Please accept the assurances of my highest consideration.

(signed)
Dr Abdel Ghaffar Khallaf
Head of the Delegation

1 Reproduced in part 4(b), pp. 64-67.
8. COMMUNICATION RECEIVED BY THE DIRECTOR-GENERAL
FROM DELEGATIONS OF 17 MEMBER STATES OF
THE EASTERN MEDITERRANEAN REGION

At the request of the delegations of Bahrain, Democratic
Yemen, Iran, Iraq, Jordan, Kuwait, Lebanon, Libyan Arab
Jamahiriya, Oman, Qatar, Saudi Arabia, Somalia, Sudan, Syrian
Arab Republic, Tunisia, United Arab Emirates and Yemen, the
Director-General has the honour to submit the following
communication to the Thirty-third World Health Assembly for
its information.

Dear Sir,

We, the undersigned representatives of Member States in Sub-Committee A of the
Eastern Mediterranean Region, in consideration of the resolution adopted by regional Sub-
Committee A at its special meeting held on 9 May 1980, in Geneva, concerning the transfer
of the Regional Office from Alexandria to Amman, Jordan, and in view of the severance of
diplomatic relations between the majority of the States in the Region and the host State,
and the subsequent measures affecting the working relationships between the States in the
Region and the Regional Office in its present location, this resolution having been adopted
in accordance with their terms of reference as provided by Article 50 of the WHO Constitution;

Whereas it is impossible for us to deal with the Regional Office as long as it is in its
present location in Alexandria, we request you to take note of our decision:

(a) to completely boycott the Regional Office in its present location and not have any
dealings whatsoever with it, as from today, 19 May 1980;

(b) to deal directly with the Organization's Headquarters in Geneva, through the
Director-General, for the implementation of the health projects approved by our States,
without any interference from the Regional Office;

(c) to request the Director-General to undertake all the necessary measures to transfer
all funds allocated to projects in our States from the Regional Programme to a special
programme at Headquarters in Geneva;

(d) to maintain our above decision in effect until the necessary measures are taken to
implement the decision to transfer the Office to Amman.

We are fully confident that you will continue to provide our States with humanitarian
services in accordance with the basic principles laid down in the Constitution of our
Organization.

With best regards,

Yours faithfully,

(signed)

Delegations of:
Bahrain, Democratic Yemen, Iran, Iraq,
Jordan, Kuwait, Lebanon, Libyan Arab
Jamahiriya, Oman, Qatar, Saudi Arabia,
Somalia, Sudan, Syrian Arab Republic,
Tunisia, United Arab Emirates, Yemen

19 May 1980

[33/INF.DOC./13 - 20 May 1980/}
ANNEX 3

STUDY OF WHO'S STRUCTURES IN THE LIGHT OF ITS FUNCTIONS

[A33/2 - 13 March 1980]

1. The Director-General's report to the Executive Board at its sixty-fifth session in January 1980, containing his conclusions from the above study, is attached as an appendix. A lively discussion on this report took place in the Board, which is reflected in the summary records of the session. The Board finally adopted resolution EB65.R12 on the matter. In this resolution, the Board recommended that the Thirty-third World Health Assembly adopt a resolution that is crucial for the future work of the Organization.

2. The Health Assembly is invited to review the study, and in particular the draft resolution proposed by the Executive Board in its resolution EB65.R12.

Appendix

STUDY OF WHO'S STRUCTURES IN THE LIGHT OF ITS FUNCTIONS:
WHO'S PROCESSES, STRUCTURES AND WORKING RELATIONSHIPS

[EB65/18 - 29 November 1979]

Report by the Director-General

In 1978 the Thirty-first World Health Assembly, having considered 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 in resolution WHA31.27 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, and to report thereon to the sixty-fifth session of the Executive Board in January 1980. In the same resolution, the Health Assembly requested the Executive Board to report on its review of the Director-General's study to the Thirty-third World Health Assembly.

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1. See resolution WHA33.17.
In compliance with this resolution I prepared a background paper entitled "Study of WHO's structures in the light of its functions". This paper was studied by various subcommittees of the regional committees and their reports were reviewed by the regional committees at their 1979 sessions. The paper was also reviewed within the Secretariat by the Regional and Headquarters Programme Committees and by the Global Programme Committee.

The report that follows represents my own conclusions from the study. To arrive at these conclusions I have carefully reviewed the reports resulting from the above-mentioned consultations and have drawn heavily on them. The need for succinctness, however, did not permit the inclusion of all the diverse views expressed by Member States in the regional committees. For these, I should like to refer the Board to the reports and resolutions of the regional committees. I take this opportunity of thanking all those who have contributed to this study.

The full report on the study consists of: (1) the present document, containing the Director-General's conclusions on WHO's processes, structures and working relationships, together with six annexes\(^1\) containing the reports and resolutions thereon of the regional committees; and (2) three addenda\(^2\) that form part of the study, on (a) periodicity of World Health Assemblies, (b) membership of the Executive Board, and (c) outline of a possible study on the feasibility of relocating WHO headquarters.

In this report, I have interpreted the term "structures" broadly to include the processes, organs, organizational structures, mechanisms and working relationships involved in efforts to attain the Organization's objectives and to make rational and optimal use of its resources, subjects that were touched upon in all the regional studies. In view of this, and of the deep involvement of Member States in the study throughout the past year, this study constitutes a managerial review of unprecedented magnitude, dealing as it does with the way the Organization acts and reacts at all policy and operational levels.

In compliance with resolution WHA31.27, I am submitting the study that follows to the Executive Board for its review.

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\(^1\) Not reproduced here.

\(^2\) Reproduced in document EB65/1980/REC/1, Annexes 8-10.
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The goals of WHO

1. The main goal for WHO in the coming decades as defined by the World Health Assembly is the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. This implies unswerving efforts to attain that goal, based on firm decisions on priorities.

2. Efforts to attain this goal will also contribute to the New International Development Strategy in fulfilment of the New International Economic Order. The Organization's cooperative activities within the United Nations system will have to concentrate on joint efforts to formulate and implement the New International Development Strategy and to establish and maintain the New International Economic Order. This too implies firm decisions concerning the Organization's priority activities within the United Nations system.

Support to strategies for health for all

3. The main thrust of the Organization's activities over the coming decades will be to support national, regional and global strategies for attaining health for all by the year 2000. Such support must promote the self-reliance of Member States in health matters, that is their capacity to make decisions autonomously, to set health goals and devise ways of attaining these goals, to rely mainly on their own human and financial resources, and to decide when and for what purposes to seek external resources. Self-reliance is not synonymous with self-sufficiency; no country can be entirely self-sufficient in health matters. Interdependence based on voluntary cooperation among equal partners is completely compatible with self-reliance and is indeed a manifestation of mature self-reliance.

4. Priority support will have to be given to the needs of developing countries, but the needs of developed countries too will not be neglected.

Nature of WHO

5. It is tacitly assumed that WHO will continue to exist. The question has to be asked if countries could attain without WHO the goal of health for all that they have defined. If governments feel that they do need such an organization, the crucial question is what kind of organization.

6. According to its Constitution WHO is an organization of Member States cooperating among themselves and with others to promote the health of all people. This cooperative action is the key to WHO's potential usefulness, because it embodies the truly international as opposed to supranational nature of the Organization. Such cooperation has to take place not only within regions, but also across regions and on a worldwide scale if the ambitious main health goal of Member States is to be achieved.

Functions of WHO

7. The voluntary acceptance by Member States of the cooperative nature of their action within WHO makes it possible for WHO to fulfill its constitutional function as the directing and coordinating authority on international health work without infringing on national sovereignty. But international health work has to begin in countries and end in countries if it is to have concrete value.

8. WHO's directing and coordinating function permits its Member States to set collectively the health goals they desire and to define the principles required to attain these goals. It also permits them to act collectively in smaller and larger groupings to attain these goals, as well as to act individually by applying in their own countries the health policies and principles that they have adopted collectively.

1 Resolution WHA30.43 (1977).
THIRTY-THIRD WORLD HEALTH ASSEMBLY

9. The above principles are fundamental to everything that follows. If Member States accept these principles they will be able to use their Organization effectively to attain their main health goal; if they do not, the Organization will have only marginal utility as a minor funding and supply agency. These principles are also the key to the proper use of WHO's technical cooperation function. The concept of technical cooperation has replaced the former approach of technical assistance, which was based on a donor/recipient relationship between the Organization and its Member States. Technical cooperation for health implies true partnership to attain national health goals that have been defined in countries by countries; these goals are attained through action that can be sustained and developed further by the Member State concerned when the involvement of WHO or of other Member States is no longer required. Such technical cooperation can be the key to wise investments in health by the country itself and, at the request of that country, by the international community. It can thus facilitate self-reliant health development, since what it generates gives rise to sustained investments and accompanying developmental action under the control of the Member State concerned.

10. The Organization has important functions with respect to three kinds of technical cooperation: (1) technical cooperation between individual Member States at their request and the collectivity of Member States that is WHO; (2) technical cooperation between developing countries which WHO has a duty to support at their request; and (3) technical cooperation between developing and developed countries which WHO also has a duty to support at their request.

11. In connexion with technical cooperation between individual Member States and WHO, the question has been raised whether the Organization is not concluding an agreement with itself. The answer to this question is that, in accordance with the advisory opinion of the International Court of Justice with respect to the United Nations, WHO is an international organization and as such possesses an international personality under international law. An agreement concluded between WHO and a Member State for technical cooperation thus constitutes an agreement between two subjects of international law, namely WHO and a Member State.

12. The Organization's directing, coordinating and technical cooperation functions can on no account be considered as being separate. Through its directing and coordinating functions the most relevant health goals for Member States and the most suitable ways of attaining these goals are defined. These goals and ways of attaining them then form the most useful basis for technical cooperation activities between Member States and WHO and among themselves. But technical cooperation involving true partnership to attain well-defined national health goals is the best way to lead to the identification of relevant international health goals and of appropriate ways of attaining them. So, if the Organization's coordinating and technical cooperation functions are properly carried out, they will become mutually supportive and intimately interwoven to the extent that any distinction between them becomes artificial and blurs the real nature of the international health work the Organization performs in accordance with its Constitution.

13. The Organization's role with respect to information transfer illustrates the inseparability of its coordinating and technical cooperation functions. The coordinating function includes capitalizing on WHO's neutrality to ensure the availability of valid information that will permit Member States to make rational decisions on health technology and on health systems. Such transfer of valid information is an activity that has to be greatly strengthened. To ensure that information is valid demands a willingness on the part of Member States to participate in its generation and selection, and a readiness to use it however much it may contradict existing beliefs and dogmas. The generation and use of such information is the key to the international transfer of appropriate technology, which should encompass the whole of health technology, aiming at generating acceptable technology that can easily be applied by the health system, no matter how complex the research required to generate it. The insistence of Member States on WHO using the information it has found valid, and making sure that whoever sets foot in any Member State on the Organization's behalf uses it also, is the key to ensuring that technical cooperation between Member States and WHO will be based on the best standards, even if these are not always the ones that are conventionally applied. And if, in addition, before Member States request technical cooperation, they make sure that the subjects of such cooperation are highly relevant to their strategies for attaining health for
all their people, this will go far towards ensuring that WHO's coordinating and technical cooperation functions are used in such a way as to provide mutually enhancing support whatever its nature and whatever its source.

Social, political and technical roles

14. To enable the Organization to support Member States adequately in attaining their health goals, it has to fulfil a balanced combination of social, political and technical roles. It is necessary to explain the real nature of these roles, particularly in view of the misinterpretations that have been given to them.

15. WHO's social role is characterized by its humanitarian efforts to promote social justice in health matters, particularly through a more equitable distribution of health resources among and within countries. Health politics deal with health policies aimed at bringing about change for the better in health situations, and the political, social, legislative, administrative, economic, and technical measures required to realize these goals. Health policy is closely linked with social and economic policy, yet is often underestimated or ignored by policy makers. It is therefore necessary to strive to have health recognized as a legitimate contributor to development, worthy of investment, and not merely a beneficiary of development. This has become known as the political struggle for health. If the health sector in Member States is involved in it, WHO, in fulfilment of its directing and coordinating function, has to engage the struggle at the international level in support of national endeavours. The Organization's sociopolitical role therefore has to be interpreted in the sense of supporting national action aimed at inducing change for the better in health situations through collective definition by Member States of health goals, the adoption of principles for realizing them, and the promotion of the reforms in the health and related socioeconomic sectors that will enable the goals to be attained. In other words, this role implies promoting action for health, and not merely indicating how such action might be carried out.

16. The political commitment of governments is essential if Member States are to bring about the health reforms required to convert the goal of health for all into a reality. WHO cannot and should not intervene in the political affairs of its Member States, but through its own commitment, the application of sound health doctrines, and promotional activities among policy makers at top-government level, it can have a powerful influence on the health policies of governments.

17. The Organization's technical role is in no way diminished by its sociopolitical role. On the contrary, if health development is indeed an important factor in social and economic development, policy for health technology has to respond to social policy. This implies developing technologies that are effective, socially acceptable, and economically feasible. To devise such technology demands a far higher level of technical competence than summarizing conventional medical wisdom. It is this type of technical competence that the Organization must foster in Member States and develop in its own ranks.

18. Almost as a by-product of such combined sociopolitical and technical action, the Organization can be instrumental in helping to reduce international tension, to overcome racial and social discrimination, and to promote peace.

19. The Director-General acts on behalf of the Organization as a whole in conformity with the decisions and policies of the Health Assembly and under the authority of the Executive Board. In this way, he is an instrument of a sociopolitical body, and as chief technical and administrative officer of the Organization is responsible for translating policy into practice. In this respect, and in this respect only, he is a political figure in the sense that he gives effect through the activities of the Secretariat to the policy decisions of Member States as expressed by the Health Assembly and the Board. In like manner, the Regional Directors are political figures only in the sense that they give effect through the activities of the Secretariat in the region to the policy decisions of the regional committees, the Board and the Health Assembly.
Managerial support

20. To provide effective support to its Member States the Organization must ensure well-correlated action, and in particular well-correlated programme planning throughout all its echelons. To benefit most from such action Member States will be wise to ensure well-correlated action within their own health system, including rational programme development and the proper integration of health programmes into a general health system. Managerial tools, such as the process known as country health programming, are available in support of the national health development process. Managerial tools are also available for WHO's programme development process. Each of these processes should be applied in a well-coordinated manner as resolved by the World Health Assembly. If properly used, they can be invaluable in helping to identify priorities and to ensure the preferential allocation of resources to these priorities. If improperly used through overconcentration on managerial techniques rather than critical assessment of programme content, they can be counterproductive, since they may only sanctify the status quo in clever-sounding managerial terms. As part of WHO's managerial tools, its information system must continue to ensure an easily accessible collective memory of the Organization's policies and programmes; the various elements of this collective memory should be stored nearest to where they are most needed.

Multisectoral support

21. Countries will require multisectoral action to implement their strategies for health for all. WHO will therefore have to be in a position to support such action. This implies the entry of the Organization into new fields to ensure the support of other social and economic sectors, both inside and outside the United Nations system, at national and at international levels. Expertise from other social and economic sectors will be brought to bear on health development through regional and global health development advisory councils, which will be tried out initially for a period of two years. These councils should both support and be supported by multisectoral national health councils that exist or that may be created in Member States.

Problems concerning WHO's structures and working relationships within them

22. WHO has a complex structure, constitutionally based on the World Health Assembly, the Executive Board, the Secretariat and the regional arrangements. Many problems have arisen in the working relationships within this structure, problems that prompted the Health Assembly to request the Director-General to undertake the present study.

23. Side by side with the outstanding achievements, not the least of which has been the development of a whole set of public health policies that will guide world health for many years to come, a widening gap has grown between policy and practice. The constitutional regional arrangements should have helped to bridge this gap, but they are still struggling to do so. They have undoubtedly given WHO unique operational advantages. Yet these very advantages have tended to undermine the universal solidarity that is mandatory if the Organization as a cooperative of Member States is to provide the support all Members require of one another. No region alone would have had the political impact required to lead to action for attaining an acceptable level of health for all its people. All regions are in need of knowledge and resources from other regions. And the richer countries cannot permit themselves to become isolated economically, socially and politically from the poorer countries. The example of smallpox eradication serves as a striking illustration of the health interdependence of all countries, and the benefits the affluent countries can derive from health improvements in the developing countries.

24. The problem of the gap between policy and practice is closely linked to the question of centralism versus decentralism. The Member States of WHO have realized for many years that both undue centralistic tendencies and undue decentralistic tendencies could only lead to far from optimal support being given to them. The central organs of WHO have become nominally stronger, but have little control over the bulk of the Organization's activities, namely those that take place in the regions and in the countries. The regional structures too have become stronger and more independent, yet have tended to concentrate on intercountry activities and have little control over the Organization's activities in countries, and little influence in shaping overall policy. These are symptoms of national attitudes to a supranational body, and have no place in a truly international cooperative of Member States.
25. Such problems were among the reasons for undertaking vast managerial studies throughout the Organization. These include some of the Executive Board’s organizational studies, such as that on the interrelationships between the central technical services of WHO and programmes of direct assistance to Member States, and the recent study on WHO’s role at the country level, particularly the role of the WHO representatives. Then there is the study of WHO’s research management which led to the decentralization of research, the emphasis on strengthening national research capacities, and the establishment of the regional advisory committees on medical research. As a result of all these managerial studies a number of crucial issues have come to light for which solutions are being sought as part of the present study - the most ambitious managerial study the Organization has ever undertaken.

26. There is clearly a strong and urgent need to correlate better the work of the Organization at the various levels. To improve this correlation there is a need for operational decentralization under the control of Member States, the retention of ultimate responsibility for defining global policy in the hands of Member States in the Organization’s central organs, the involvement of Member States at all operational levels in shaping policy, and the control of the implementation of policy by Member States also at all levels, supreme control being exercised by the World Health Assembly.

WHO’s action in countries

27. If the work of WHO begins and ends in its Member States, WHO’s action in countries is of capital importance. But it is not so much a question of what WHO does in countries as of what Member States, as the basic building blocks of WHO, do within their country in accordance with WHO’s policies and programmes. The essence of this action by Member States is the individual application by them of what they have decided collectively in the regional committees and World Health Assembly. WHO’s policies and programmes could thus be used as examples on which to base national health policies and programmes, thereby facilitating the introduction of national health reforms that might otherwise encounter insurmountable obstacles. In this way Member States could develop their own self-reliance in health matters by using WHO as a symbol, and as a source of reference and moral support.

28. This assumes that WHO’s policies and programmes are applicable in its Member States. If they are not, they should never have been adopted. Representatives of Member States in the regional committees and delegates to the Health Assembly should therefore always keep in mind the feasibility of applying resolutions in their own country before adopting them. Having adopted these resolutions on the basis of their being feasible, they have the responsibility of explaining them to their government and their colleagues with a view to their application within the country.

29. Governments, in their capacity as leaders of the Member States of WHO, have in return the responsibility of informing the Organization of their experiences in developing and applying health policies, whether based on WHO’s policies or not, with a view to strengthening the collective ability of all Member States to define health policies and translate them into effective programmes within the framework of WHO. To absorb WHO’s policies and principles and to apply them within the national health system requires a mechanism for continuing dialogue between each Member State and its Organization. This mechanism will vary from country to country and WHO will have to make sure that it is capable of carrying out its part of the necessary dialogue. This is also the key to the question of WHO programme coordinators, formerly known as WHO representatives. If a Member State considers that it requires such an individual to ensure the interface between its own health authorities and WHO, it is entitled to have one; but it cannot relinquish its own constitutional responsibility as a Member State of WHO. The WHO representative in a country is the health authority acting on behalf of the country as a Member State of WHO.

30. This implies a role for ministries of health that is quite different from their actual role in so many countries. If WHO is the directing and coordinating authority on international health work, ministries of health would become the directing and coordinating authority on national health work within their country. Parallel to WHO at the international

level, they would have wide responsibilities within the country for promoting health development among the country's political leaders, for influencing other relevant sectors to take action required to support health improvements, and for controlling the health sector through the definition of health policies, the coordination of their translation into programmes and services to deliver them, and the monitoring and evaluation of their implementation.

31. WHO's essential role in countries is to support Member States in the above-described endeavours, as behaves a cooperative of Member States in its relationships with one of its members. The Executive Board's organizational study on WHO's role at the country level, particularly the role of WHO representatives, spelled out how this role should be fulfilled. It is now necessary for Member States individually and collectively to review the extent to which the recommendations of this study are in fact being put into practice, and in particular the mutation from technical assistance to technical cooperation.

Cooperation among countries in health matters

32. Cooperation among countries in health matters takes place without the intermediary of WHO as well as within its framework. It assumes such forms as exchanges of information on technical matters, provision of expertise, training of health personnel, financial support, and the import and export of equipment and supplies required for the health system.

33. Such cooperation is voluntary and needs no external fostering. However, if countries have confidence in themselves collectively as Member States of WHO, they may find it useful to increase their use of the Organization as a neutral intermediary to arrange and support cooperation among themselves. This applies to technical cooperation among developing countries, economic cooperation among developing countries in health matters, and technical cooperation between developing and developed countries.

34. Since the Organization's support to cooperation among its Member States should permeate all its activities, no special structures to fulfil this function are required. What is required is alertness on the part of Member States and the Secretariat at all policy and operational levels to the possibility of contributing to health improvement through such cooperation.

35. An important activity of the Organization to facilitate cooperation between countries is the collection, organization and dissemination of information on available resources, technology and expertise in the health and related sectors. WHO can also be highly useful in catalysing agreements between developing countries, between developing and developed countries, and also between developed countries, on policy, technical and commercial matters relating to health. An outstanding example of this catalytic role is the proposed servicing by the Director-General of a global health resources group, composed of representatives of developed and developing countries as well as bilateral and multilateral agencies, whose aim is to mobilize resources for health and rationalize their flow in support of strategies for health for all by the year 2000 in the developing countries.

Nongovernmental organizations

36. While WHO is an intergovernmental organization, it has to pay increasing attention to nongovernmental organizations that are interested in collaborating for the attainment of health for all. This is so in view of the importance of mobilizing all forces to this end and of the potentially significant contribution of such organizations, including their participation in genuine health technology assessment. No structural changes are required for this purpose, but rather increased awareness of the potential usefulness of these organizations, and selective support, starting with the support of governments to nongovernmental organizations in their country that are ready to apply the policies determined in WHO, and continuing through the regional and global levels.

The governing bodies

37. Collective decisions are taken by Member States in the regional committees, World Health Assembly and Executive Board, although, once designated by their government, Board
members are expected to act on behalf of the Organization as a whole and not as representa-
tives of their own country. The work of these bodies has to be better correlated as part of
the efforts to provide Member States with a well-coordinated response to their needs at all
policy and operational levels.

Regional committees

38. Member States are increasingly identifying themselves with their region and this has
been accompanied by an intensification of the work of the regional committees in recent years.
This trend must be greatly increased, the regional committees being the forum nearest to
Member States in which they can cooperate on matters closest to them. If they have mutual
confidence they can use the regional committees to exchange ideas on health policy with a
view to learning lessons for their own country, in addition to defining regional health
policy in support of their individual health policy. The review by the regional committees
of WHO's action in countries could thus assume a highly positive dimension rather than being
considered suspect in view of its potential infringement on national sovereignty.

39. An important aspect of the regional committees' work is to identify issues that require
decisions by the Board and the Health Assembly and to make proposals for appropriate global
policy. Another important aspect is to ensure the support for health-promoting activities of
other sectors in the region, and to bring the support of the health sector to regional, social
and economic endeavours related to the New International Development Strategy and the New
International Economic Order. This might imply broadening representation at regional
committees, or at least in their subcommittees, to include representatives of other sectors.

40. In addition to the generation of regional policy and the adoption of regional programmes,
regional committees will have to increase their monitoring and control functions to ensure the
proper reflection of these policies in programmes and the proper implementation of these
programmes. Such monitoring and control will have to include the review of the extent to
which WHO's activities in individual countries are in accordance with the policies, principles
and programmes defined collectively in the regional committees.

41. Recent additions to the responsibilities of the regional committees are to support
technical cooperation among developing countries and to act as guarantors of the genuineness
of country and intercountry programmes for external funding, so as to encourage the mobiliza-
tion of such funds for health, and to ensure that they are channelled into priority activities
in the strategies for health for all of the developing countries.

42. The successful application of the above principles requires careful selection of topics
for consideration by regional committees to ensure that they are of real interest to Member
States in the region, as well as careful review of the issues requiring decisions. This
underscores the importance of mechanisms that have recently come to the fore, such as
consultative subcommittees around the regional director, and subcommittees on the general
programme of work, the programme budget and various specific matters. Early dispatch of
discussion papers to countries will also facilitate wide country involvement; for such
involvement is the crux of the matter, and the best guarantee of the usefulness of the work of
the regional committees.

43. To fulfil the above functions adequately, representatives to the regional committees
must have the power to take collective decisions on behalf of their governments, realizing
the implications of such decisions for the health policies and programmes of their own
country. They must also be sufficiently senior to be able to influence the health policies
of their government in the light of collective health policy agreed upon at the regional
committee. No country should be prevented from sending a representative to sessions of the
regional committees because of financial constraints, particularly in view of the enhanced
role of these committees.

The Executive Board

44. The Executive Board too is playing an increasingly active role in giving effect to the
decisions and policies of the Health Assembly and in acting as the executive organ of the
Assembly and adviser to it. Its deliberations are becoming increasingly frank and open, and its candid dialogues deal with crucial policy issues and programme priorities. To this end it has set up a number of working groups and committees, and this is a trend that should be encouraged if the Board is to discharge the full responsibilities devolving on it in connexion with the attainment of the Organization's main goal of health for all. The Board is also playing a more decisive role with respect to the Health Assembly, at which its representatives are active in introducing programme and budget matters and in responding to the comments of delegates.

45. But the relationships between the Board and the regional committees need strengthening, both in order to enable the Board to digest policy proposals emanating from the regional committees, and in order to monitor on behalf of the Health Assembly the way in which these committees reflect its policies in their work.

46. All this has implications for the kind of documentation to be submitted to the Executive Board. Such documentation must present clearly the policy issues on which the Board's comments and decisions are required.

47. Questions relating to the membership of the Board are reviewed in Addendum 2 to this study.1

The World Health Assembly

48. The World Health Assembly has adopted a growing number of resolutions of a highly important nature for world health, and has built up a whole new set of doctrines concerning health and how to attain it. It must now become much more active in following up and reviewing the implementation of these resolutions and application of these doctrines by Member States, the regional committees, the Executive Board, and the Director-General.

49. If it is remembered that the Health Assembly is the Organization's supreme policy organ consisting of delegates of Member States cooperating among themselves, and that its power lies in the ability of these Member States to influence one another to take action rather than in the formal imposition of decisions, this monitoring and control function carries no danger of infringing on national sovereignty in health matters. On the contrary, it could transform the Assembly into the incarnation of the world's collective health conscience and could make it a greater source of strength than ever in support of individual efforts by Member States to improve their people's health. But the proper fulfilment of this function by the Assembly depends on Member States adopting resolutions only if they are convinced of the practicability of implementing them.

50. The Health Assembly has recently adopted a number of resolutions aimed at improving its methods of work. These will no doubt have to be kept under review as the full impact is felt of the assumption by the Assembly of its enhanced role in connexion with the global strategy for health for all, as well as its monitoring and control function on the one hand and the intensification of the work of the regional committees and the Executive Board on the other. Mechanisms are required to avoid the adoption of repetitious resolutions and to ensure the feasibility of implementing the resolutions adopted. This can be achieved through a combination of a stricter selection of agenda items, provision of adequate time to review draft proposals, screening of certain resolutions by the Executive Board, greater initiative of regional committees in proposing resolutions to the Assembly, and referral of certain issues by the Assembly to the regional committees for prior review. These measures, however, have to be kept flexible and the bureaucratization of procedures has to be avoided at all costs.

51. The review of the periodicity of World Health Assemblies, which is analysed in Addendum 1 to this study,2 will have to take the above factors into account.

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ANNEX 3

Improving the correlation of the work of the regional committees, the Executive Board and the World Health Assembly

52. Procedures have already been adopted for improving the correlation of the work of the regional committees, the Executive Board and the World Health Assembly. These include correlating the agenda of the regional committees and the Executive Board to include certain items in the regional committees that are timely and of common interest, so that these committees can discuss them and make their recommendations to the Board before they are discussed in the Board in preparation for the ensuing Health Assembly. Organizational studies of the Board could profit from such prior review by the regional committees. This applies too to direct relationships between the regional committees and the Health Assembly; for example, the Technical Discussions held during the Health Assemblies could be preceded by discussions in the regional committees, as was the case at their 1979 sessions in anticipation of the Technical Discussions during the Thirty-third World Health Assembly in 1980. In this way, the discussion of certain items in the regional committees would come at the beginning of the cycle of discussion within the governing bodies and the recommendations of the regional committees would have a greater influence on the work of the Board and Health Assembly.

53. At the same time, the regional committees, possibly through appropriate subcommittees, would do well to analyze more extensively the regional and national implications of Health Assembly and Board resolutions. This two-way flow of information and mutual review of resolutions should go far to ensure the internal coherence of the policies and programmes of the Organization at all levels throughout the world, at the same time leaving sufficient latitude for regional and national variations.

54. There is nothing like live human contacts to ensure consistency. Yet it would perhaps be impractical to suggest that the same national representatives should attend meetings of the regional and global governing bodies. There is thus a need to coordinate the representation of individuals representing their country in different bodies. This is a national responsibility, and would be most successfully carried out if governments seriously reviewed proposals for WHO's policies and adopted definite attitudes towards them. This would help their representatives to speak with one tongue and to report back to a national coordinating mechanism in pursuance of a cycle of coordination of national representation.

55. No formal briefing of national representatives by the Secretariat can adequately replace such internal national coordination. But the Secretariat has an added responsibility to phrase policy proposals in clear language and to specify the issues for which decisions are being sought.

The Secretariat

56. The function of the Secretariat is to support the Organization's Member States individually and collectively. The Secretariat has no independent existence of its own. This in no way diminishes its importance. On the contrary, its competence and integrity are more important than ever in the light of its function of supporting a cooperative of Member States with more than 150 diverse needs. For Member States depend heavily on the information submitted to them by their Secretariat; the absolute reliability of the Secretariat in providing this information is mandatory if confidence is to reign. This underscores the need for much stronger correlation of the work of the Secretariat at all levels in order to ensure its consistency. The present situation in this respect leaves much to be desired.

WHO staff in countries

57. Field staff, to the extent that they will be engaged in the future in the light of the increasing mobilization of national resources and consequent employment of national personnel, and the execution of WHO-supported programmes by the government concerned, will have to identify themselves with the national programme in which they are working and to feel part of the national health personnel.

58. As mentioned in paragraph 29 above, the overriding responsibility of governments and their accredited health authorities for the work of WHO in the country places the role of
WHO programme coordinators are to be accorded the freedom and conditions of employment necessary to enable them to perform their functions properly and effectively. This freedom is essential if they are to have no other role than that of regional programme coordinator. If they are employed, however, they must be given maximum freedom and adequate resources to fulfill the functions ascribed to them in the Executive Board's organizational study on WHO's role at the country level, particularly the role of the WHO representatives. It appears that the change of title from "WHO representative" to "WHO programme coordinator" has been misinterpreted in a number of countries as a diminution of their functions and responsibilities and in consequence as a demotion, an interpretation that was never intended. This being the case, it is suggested that their title again be changed, to that of "WHO representative and programme coordinator" (WRPC).

Regional offices

60. The policies of decentralization and regional self-reliance, intensified dialogues with Member States, the understanding of the Secretariat's role in supporting Member States and, particularly at the regional level, in ensuring technical cooperation between the Organization and its Member States, the catalytic role of WHO in support of technical cooperation among countries and in particular among developing countries, the need to provide new kinds of information to the regional committees, their subcommittees, the regional health development advisory councils, and various regional expert panels, and new ways of mobilizing and using national expertise, must all affect the type of work to be carried out by the regional offices and the workload on their staff. There is a need to review the staff complement in each of the regional offices to ensure that it will be able to cope with their additional functions.

61. No two regional offices can be identical in their internal organizational structure, but adequate response to the composite programme needs of Member States, as opposed to the former "vertical" programme support, implies the establishment of multidisciplinary functional programmes and appropriate coordinating mechanisms rather than administrative units. It also implies mechanisms to ensure that individual countries and groups of countries in the region are adequately served.

62. This pattern of work has clear implications for the types of staff required in regional offices. There is an increasing need for staff who are capable of working in multidisciplinary teams, of mobilizing national expertise, of synthesizing such national expertise and experience into regional programmes, and of distilling essential information from detailed data in a number of fields for dissemination to countries. This information will also be used to prepare documents that will help the regional committees to make rational decisions based on political, social and economic factors in addition to technical factors.

63. The need for a better understanding of the place of health development in general social and economic development, and for multisectoral support to strategies for health for all on the one hand, and the relative inexperience of the Organization in these matters on the other, have given rise to the idea of creating regional health development advisory councils with multisectoral representation to advise the Regional Director. It is hoped that such advisory groups will help the Regional Directors to support the regional committees adequately on all issues involving multisectoral policy and action for health development.

Headquarters

64. Decentralization does not imply that there is no further need for headquarters; on the contrary, it gives the work of headquarters a new dimension in keeping with the new dimensions of the Board and Health Assembly and the relationships between them and the regional committees as suggested above. This dimension can be summed up as global stimulation through the generation of ideas, as well as the analysis, synthesis, articulation, and promotion of ideas,
irrespective of who at what level sparked them off; and global coordination on behalf of the Board and Health Assembly. This coordination is destined to ensure the provision to the Board, the Health Assembly and the regions of valid information on health systems and technology, including the policy and programme analysis and technical assessment required to arrive at this information. It is also destined to foster coherent programme development, irrespective of the level or levels at which the various programme elements originated. In addition, there is still a need for the central organization of global programmes, whether the core groups for these programmes reside in headquarters or in one of the regional offices, or have outposts in regional offices or national institutions. At the same time, headquarters must continue to provide support to the regional offices at their request.

65. In a similar manner to the regional level, the Director-General will have the benefit of multisectoral advice from a global health development advisory council to enable him to support the Board and Health Assembly adequately on all issues relating to health development in its multisectoral dimension, including the contribution of health to the New International Development Strategy and the New International Economic Order.

66. The question of expert advice to the Organization in general is currently under review in 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,1 and is therefore not touched upon in this study.

67. Headquarters will also have to assist the Director-General in supporting the global health development advisory council (see paragraph 65) and the "health/2000 resources group" (see paragraph 35). This will require quite a new type of Secretariat support: in the case of the global health development advisory council, to provide documentation to, and participate in the deliberations of, a group whose function is essentially the promotion of multisectoral action for health and whose members from other social and economic sectors are on a par with those from the health sector; and in the case of the "health/2000 resources group", to analyse trends, identify gaps and recognize opportunities in bilateral and multilateral development assistance for health over which WHO has no direct jurisdiction.

68. The ideal organizational structure of headquarters has not yet been found. Indeed, there may be no such thing as an "ideal organizational structure"; the structure may have to undergo an evolutionary process in response to the evolution of global policies and programmes. At this stage, the trend towards the organization of headquarters by global programmes rather than divisions and units will have to be encouraged, in spite of the managerial problems involved in trying to ensure that these programmes emit coordinated signals to the Board, the Health Assembly and the regions.

69. The new nature of the work of headquarters must naturally influence its staffing pattern. The headquarters regular staff complement has been drastically reduced in fulfilment of resolution WHA29.48, but it will have to be further reviewed to ensure a proper balance between it and the regional office staff complements in keeping with their respective emergent workloads. The Secretariat at headquarters and in the regional offices will have to be strengthened by a type of person who is all too rare. There are technical specialists of all types in the countries and in WHO; there are far too few specialists in the composite discipline of health development. By that is meant people who are imbued with the philosophy of health development as defined in WHO; who can generate such development, plan for it, programme and budget for it, implement it, monitor it, and evaluate it; who can bring together to these ends the specialized knowledge of all the other disciplines involved in the health, political, social, and economic sciences, and who can marshal, master and summarize the information required for all these activities. This is an important recruitment and training challenge that lies ahead of the Organization. It will be necessary to create this type of person in sufficient numbers within Member States themselves if they are to make real progress with their health development strategies. When there are sufficient numbers in countries, there will be no problem in recruiting suitable staff of this type for WHO.

70. This in no way implies that headquarters and the regional offices will be staffed only by the kind of "health generalists" described above. A proper balance will have to be maintained between this type of staff and the currently predominant type of programme-specific staff, depending on the changing needs of programme support to Member States and on the need for coordinated programme development and implementation. So whenever recruitment policy is discussed it is necessary to keep in mind the needs of functional distribution side by side with geographical distribution.

71. The question of the location of headquarters was raised at recent sessions of the Board and at the Thirty-second World Health Assembly. An outline of a possible study on the feasibility of relocating WHO headquarters appears as Addendum 3 to this study. 1

Improving the work of the Secretariat

72. To enable the Secretariat to support Member States properly at all levels it has to maintain adequate internal cohesion. One way of ensuring this, and yet retaining control, is to encourage free contacts on technical matters, but to maintain formal contacts on policy and budgetary matters. This should permit wide exchanges of views between staff at all levels on technical questions without administrative hindrance; but at the same time firm control by middle and top management of policy and budgetary matters.

73. Mechanisms to ensure coordinated action have been created by the establishment of Regional and Headquarters Programme Committees and the Global Programme Committee. These committees should now form a permanent feature of the Secretariat, the Regional and Headquarters Programme Committees ensuring coordinated programme management within their fields of competence, and the Global Programme Committee ensuring coordination of the management of the Organization's programme on a global scale. If used properly, these mechanisms could strengthen the hand of the Director-General by ensuring that the Secretariat supports Member States individually and collectively with the necessary degree of consistency at all levels. For example, the dedicated involvement of the Regional Directors in the Global Programme Committee, together with the Director-General, the Deputy Director-General and the Assistant Directors-General, should ensure that, in providing top level programme policy support to the Director-General, maximum account is taken of the needs of Member States as expressed through the constitutional regional arrangements. The proper use of these mechanisms, however, implies the readiness of their members to tackle all issues, no matter how sensitive, in a collegiate manner, to hold wide staff consultations in order to ensure adequate staff participation in the work of the Organization, and to provide firm guidance to staff on the Organization's policies so that they function within a well-defined policy framework. It also implies the readiness of their members, as well as of those who report to them, to sacrifice some of their individualism in favour of common efforts.

74. The Secretariat, as part of the Organization in general, is passing through a transitional period of new challenges and decentralized efforts, in consequence of which new roles are devolving on the regional offices and on headquarters. If the emphasis at regional level lies more in technical cooperation with Member States and supporting technical cooperation among Member States, the emphasis at headquarters lies more in the Organization's coordinating function. Since, as stated in paragraph 12 above, these two functions are mutually supportive, it follows that regional office and headquarters staff must be mutually supportive. Any mutual mistrust or antagonism must become a thing of the past and must give way to mutual respect based on an understanding of the respective roles of the regional offices and of headquarters.

75. Mutual confidence can be strengthened by interchanging the functions of certain staff within regional offices and headquarters, and between field posts, the regional offices and headquarters, leading to a flexible process of staff rotation. This, however, is fraught with difficulties of an administrative, financial and personal nature. Serious thought will have to be given to ways of resolving these difficulties.

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76. No less an important and complex issue is the secondment of national personnel to the WHO Secretariat for limited periods. Such rotation could be of benefit to all concerned; it could provide useful experience to national personnel from which their countries would benefit on their return, and it would ensure the constant influx of fresh ideas into the Secretariat. At the same time, a certain degree of continuity of concepts and action has to be maintained. To maintain this continuity, certain staff will have to be retained for longer periods than others, depending on the nature of the functions required within the Secretariat at that time, the need for a proper balance between generalist and specialist staff as mentioned in paragraph 70 above, and the individual capabilities of staff members. Particular attention will have to be paid to the duration of office of top-level management.

The Director-General and the Regional Directors

77. The Director-General and the Regional Directors, while members of the Secretariat, are in a special category in that they are elected by Member States, the former being appointed by all Member States, and the latter nominated by the Member States in the region concerned. This undoubtedly renders them vulnerable to the exigencies of individual governments, acquiescence in which could jeopardize the very existence of the Organization as a cooperative of Member States. The best way of protecting the Director-General and the Regional Directors from this danger is for governments to make sure that their individual demands on the Organization conform to the policies they have adopted in the regional committees and the Health Assembly. At the same time, the Director-General and the Regional Directors must have the right and the obligation to act on behalf of the collectivity of Member States in refusing government requests that are unreasonable in their aberration from the Organization’s policies.

Control of the WHO system

78. The World Health Organization has a complex system, yet it can and must be controlled. To be effective, the Organization must achieve unity within its pluralistic system, avoiding any tendency towards seven independent and possibly competing regional and global organizations. Ultimate control lies with Member States individually and collectively, with the support of the Secretariat.

79. To achieve this control, Member States will have to tighten the coordinating mechanisms, first of all within their own country, so that they are able to ensure the mutual relevance and support of their own health development strategy and of their technical cooperation with WHO and with other Member States of WHO. They will have to make sure that what they do in their country is taken into account in the regional committees, that what they decide in the regional committees gets proper attention in the Health Assembly and the Board, and that Board and Health Assembly resolutions are properly reflected in the work of the regional committees and in their individual health policies. If Member States are serious about using WHO to support them in attaining an acceptable level of health for all their people, it is they who must make sure that every part of the Organization plays its proper role to this end. At the same time it is the responsibility of the Director-General to ensure that the Secretariat at all levels provides Member States with the support they require to control the Organization as a whole.

Epilogue

80. Many of the above conclusions are already in the process of being introduced with the concurrence of the governing bodies; others await their approval. The Organization will have to adapt itself to the consequences of any decisions it takes in connexion with its functions, structures, processes and working arrangements. A period of running in will no doubt be required until the ways the structures are used, the processes applied and the working arrangements carried out become part and parcel of the Organization's everyday life. At the same time, these measures will have to be constantly assessed in the light of the speed and effectiveness of WHO’s action, its efficiency, and the satisfaction felt by Member States and the Secretariat.
Recognizing that this item is most important for all subsequent WHO activities and in order to bring together related issues of other agenda items, the Executive Board decided, at its sixty-fifth session, to present a report to the Thirty-third World Health Assembly for its information, giving:

(1) a description of the historical framework within which the review of progress is being undertaken, with a summary of all important decisions taken by the Board in this regard;

(2) a brief summary of progress at national, regional and global levels;

(3) a review of critical issues identified by the Board during its discussion of this item; and

(4) a reference to resolution EB65.R11 in connexion with resolution 34/58, adopted by the United Nations General Assembly on 29 November 1979.2

The report that follows is structured to meet the above requirements. Its contents include relevant portions drawn from the report of the Programme Committee of the Executive Board and the Director-General's report to the Programme Committee on this subject.3

I. INTRODUCTION

1. The main social target of governments and WHO in the coming decades is "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". This has come to be known popularly as "Health for all by the year 2000", and there is still some uncertainty as to its meaning. To understand it, it is necessary to refer to WHO's Constitution, which has defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." This definition is based on a social ideology, and is an idealized concept of health. In reality, health in these terms may be well-nigh unattainable. However, the objective of WHO as defined in its Constitution is "the attainment by all peoples of the highest possible level of health". The goal of health for all by the year 2000

1 See resolution WHA33.24, and the discussions at the Health Assembly (document WHA33/1980/REC/3, summary records of Committee A, third meeting, section 2; fourth and fifth meetings; sixth meeting, section 1; and fourteenth meeting, section 1).

2 Reproduced in the Appendix (p. 107).

embody that objective. It emphasizes "highest possible", so that countries will strive to improve the health of their people in keeping with their own particular social and economic capacities. By the year 2000 all people in all countries should have a level of health that will permit them to lead socially and economically productive lives. In deciding on this target in resolution WHA30.43, the Thirtieth World Health Assembly, in 1977, took a step of utmost importance for those responsible for and concerned with the health of all people. The International Conference on Primary Health Care, jointly sponsored by WHO and UNICEF and held in September 1978, culminated in the adoption of the Declaration of Alma-Ata, in which it is stated that primary health care - which forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community - is the key to attaining this target.

2. In 1979 the Thirty-second World Health Assembly, in resolution WHA32.30, endorsed the report of the International Conference on Primary Health Care including the Declaration of Alma-Ata, and invited 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. Furthermore, this resolution requested 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.

3. The detailed timetable for formulating strategies for health for all by the year 2000 calls for the Member States to submit reports on national strategies by June 1980. It also requests the Executive Board to review progress and to report to the Thirty-third World Health Assembly. This report is meant to serve this latter purpose.

4. In preparing this report, the Executive Board examined the reports of its Programme Committee and the Director-General on this subject. The Director-General's report summarized initial progress reported upon by countries, the results of the regional committee discussions, including relevant resolutions adopted by the regional committees, and WHO support to strategy formulation. The Executive Board also considered the United Nations General Assembly resolution 34/58, "Health as an integral part of development", to which it attached the highest importance.

II. FORMULATING STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000: THE CENTRAL THEME OF THE WORK OF THE MEMBER STATES AND WHO

5. The Executive Board underlined the vital importance of this subject to the work of the Member States and the Organization. It stressed that this is the central theme which all other activities of the Organization should and must support. It is through the strategies, formulated by Member States and the Organization, that the commitment to social justice embodied in resolution WHA30.43 and the Declaration of Alma-Ata will be realized. The unanimous adoption by the United Nations General Assembly of resolution 34/58 reflects the importance of this matter within the international community. The resolution's support to

1 Document WHA32/1979/REC/1, p. 27.
2 Document WHA32/1979/REC/1, Annex 2.
3 Approved by the Executive Board at its sixty-fourth session and reproduced in Annex 2 in document WHA32/1979/REC/1, p. 79.
4 Document EB65/4.
5 Reproduced in the Appendix (p. 107).
the actions called for in the Alma-Ata Declaration and to the formulation of national, regional and global strategies should be used to reinforce national and international commitment to achieving health for all by the year 2000.

6. The review of the Programme Committee's report on the subject of "Monitoring of the implementation of programme budget policy and strategy" brought into evidence some of the changes that are required if this monitoring process is to contribute effectively to the monitoring of progress towards the achievement of health for all by the year 2000. With the implementation of resolution WHA29.48 assured, the Board considered the question of how best to monitor the future contribution of programme budget policies and strategies in the light of the national, regional and global strategies at present being formulated. The Board stressed the importance of national strategies addressing clearly the role of technical cooperation between WHO and its Member States and among the Member States themselves in strategy formulation and implementation. It noted that the decisions to be taken with regard to the item of WHO's processes, structures and working relationships in the light of its functions were particularly critical in this regard.

7. The Board's review of the Programme Committee's report on the Sixth General Programme of Work led to the adoption of resolution EB65.84, which, inter alia, "approves the work carried out by the Organization in the field of medium-term programming as one of the most important tools in the management of the WHO programme activities, since it ensures a continuing and permanent link between policies and principles established by the Health Assembly, the General Programme of Work covering a specific period, and ongoing programme budgeting at all levels", and requests the Director-General "to explore further the usefulness of the medium-term programming process as a means of achieving the goal of health for all, in general, and, specifically, facilitating the appropriate interaction or integration of programmes at headquarters, regional and country levels". Although not explicitly included in this resolution, the Board reiterated the importance of using the mechanism of country health programming. In addition to being a useful managerial tool for national health development, it could also help to link national with international programmes.

8. The Board's review of the Programme Committee's report on the Seventh General Programme of Work led to the request that the Programme Committee should continue its work on the preparation of proposals on the nature, objectives, structure and method of preparation of the Seventh General Programme of Work. The Board noted that, while fully responding to the new challenges set by the goal of health for all by the year 2000 and the duty of the Organization to respond adequately to the needs of Member States in support of their individual and collective strategies for attaining this goal, the Seventh General Programme of Work should incorporate all that is essential in the Sixth General Programme of Work to ensure continuity.

9. The Board's consideration of the Director-General's report on the study of WHO's structures in the light of its functions led to the adoption of resolution EB65.12 which recommends, inter alia, that the Organization concentrates its activities "over the coming decades, as far as is possible in the light of all its constitutional obligations, on support to national, regional and global strategies for attaining health for all by the year 2000". In this regard the resolution urges the regional committees "to intensify their efforts to develop regional health policies and programmes in support of national, regional and global strategies for health for all, and to consider establishing or strengthening appropriate subcommittees to this end", and requests the Executive Board "to strengthen its role in giving effect to the decisions and policies of the Health Assembly and in providing advice to it, particularly with respect to ways of attaining health for all by the year 2000, among other things by ensuring that the Organization's general programme of work, medium-term programmes, and programme budgets are optimally oriented towards supporting the strategies for health for all of Member States".

1 Document EB65/7.
2 Document EB65/6.
3 Document EB65/5 Rev.1.
4 Annex 3 in this volume and document EB65/1980/REC/1, Annexes 8, 9 and 10.
III. PROGRESS OF THE MEMBER STATES IN FORMULATING NATIONAL STRATEGIES AND RELATED WHO SUPPORT

Political commitment

10. Almost all countries have indicated a high-level political commitment to health for all. Many national reports highlighted the commitment already contained in important national documents such as the national constitution and national development plans. In many instances, political commitment has taken the form of programme speeches or statements by the Heads of State or Government; in others, commitments have been included in the form of fundamental policies on social and economic development. This commitment has not only been forthcoming from developing countries. A number of industrialized countries have associated themselves with health for all, more specifically with the need to ensure universal access to primary health care as a part of a comprehensive health services system.

11. High level political commitment was promoted through activities on the part of the Secretariat. Resolution WHA32.30 was sent to high-level leaders of all Member States attached to a letter from the Director-General in which the importance of the social goal of health for all by the year 2000 was noted. This was followed by contacts with these leaders, including Heads of State, on the part of the Director-General, Regional Directors, and supporting staff. Particularly worthy of note was the presence and participation of Heads of State in two of the regional committees.

Importance of technical cooperation

12. In expressing their belief that health for all can be achieved in spite of the conflicting evidence afforded by recent history and present trends, many Member States stressed the need for a renewed spirit of cooperation among nations. This plea was expressed as part both of their recognition of the importance of the strategy of technical cooperation among developing countries (TCDC) and of their call for a longer-term and increased commitment of assistance for the development and implementation of national plans of action. Nearly all countries noted that it would not be feasible to achieve health for all without adequate mobilization of resources, both nationally and internationally. United Nations General Assembly resolution 34/58 should be exploited fully to facilitate the mobilization of the necessary resources.

Intersectoral collaboration

13. Many references were made to the fact that health cannot be achieved by the health sector alone. This understanding underlined the importance given to the strengthening of mechanisms for promoting and achieving intersectoral action and support both as an integral part and for the promotion of primary health care. Some countries were able to point to existing high-level interministerial coordinating mechanisms which effectively link the health sector to overall socioeconomic development. A number of countries made specific reference to integrated rural development plans of which health development was an integral part. However, a greater number, while identifying the problem of achieving intersectoral collaboration as one of great importance, did not indicate the existence of such coordinating programmes.

14. Of the measures being taken to strengthen intersectoral action and support, particular mention should be made of the creation of coordinating mechanisms of the national health council type which have a multidisciplinary and multisectoral nature. Many countries have set up or envisage setting up councils of this kind. Some referred to the need to "revitalize" existing councils. Many described the existence of similar bodies covering provinces, regions and districts. In some instances, these developments have required the reorganization of the structure of the Ministry of Health, particularly with regard to mechanisms for planning, programming and coordination. A few countries have used workshops and seminars at central, regional, district and peripheral level to promote collaborative action. Others have created multisectoral task forces responsible for formulating national strategies for health for all. Countries which have undertaken country health programming refer to this approach as favouring development of intra- and intersectoral coordination.

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1 Based upon the Director-General's report to the Programme Committee of the Executive Board (document EB65/PC/WP/4, annexed to document EB65/4) and information reported upon during the discussions of the Board.
15. Several countries envisage using WHO support in the process of formulating policies, strategies and plans of action. Some express this in general terms, others more specifically - for example, seeking WHO’s collaboration:

(i) in carrying out country health programming;

(ii) in strengthening technical cooperation with other countries;

(iii) in the enhancement of managerial and administrative skills needed;

(iv) in strengthening existing institutional arrangements to serve as the basis for a national centre for health development;

(v) in assessing the effectiveness of measures taken to attain an acceptable level of health for all, and monitoring of progress.

16. WHO technical support to national strategy formulation has been organized in a variety of ways. This has included briefing and orientation of WHO programme coordinators, national programme coordinators, and key national staff. In the African Region joint UNICEF/WHO workshops and seminars are being planned for key nationals with senior UNICEF and WHO staff. The first such workshop is scheduled to be held in Mozambique early in 1980 for six English-speaking countries. It is planned to hold a similar workshop for French-speaking countries in the Region. In the Region of the Americas this was done through a series of meetings; six subregional meetings have been held to date, with the participation of 40 high-ranking national officials and 48 staff members of the Region. In the South-East Asia Region a joint UNICEF/WHO meeting was held in December 1979 on the formulation of strategies for health for all, with primary health care as the key approach. It was attended by high level representatives from the Member States, WHO programme coordinators, and UNICEF representatives. Principles and work plans for the formulation of national strategies were agreed upon. In the European Region the Regional Committee approved a questionnaire for use by governments, and governments have been asked to give their views in writing by February 1980, using the questionnaire as a basis for their replies. In addition a special task force has been set up to pursue studies at the regional level as requested by the Regional Committee. An important element in the work of the Eastern Mediterranean Region is the Regional Consultative Committee constituted earlier in 1979; composed of five distinguished leaders in health and education from the Region, this Committee has advised on critical aspects of regional strategy formulation. In the Western Pacific Region a special multidisciplinary task force has been constituted; it will visit each country and work with national personnel in the preparation of national strategies.

17. The existing internal coordinating mechanism of the Secretariat, consisting of regional programme committees and a Headquarters Programme Committee and guided by the decisions of the Global Programme Committee, is being used for supporting strategies for health for all by the year 2000. The Global Programme Committee, consisting of the Director-General, Deputy Director-General, Regional Directors and Assistant Directors-General, met in January and May 1979 to review the support that might be required by WHO in the formulation of strategies for attaining an acceptable level of health for all by the year 2000. Three main areas of support were identified: formulation of strategies and plans of action, the progressive implementation of these, and their monitoring and evaluation. A series of actions was agreed upon, including the means for communicating the results of the Executive Board and Health Assembly to the Member States, the holding of regional and intercountry meetings for briefing and exchange of views on strategy formulation, the discussion of health for all during the 1979 sessions of the regional committees, the preparation of guidelines on critical aspects of strategy formulation, the establishment of regional and global health development advisory councils, promotional action required to stimulate political, social and economic support from other sectors and from international and regional governmental and nongovernmental organizations, and the strengthening of mechanisms for attracting bilateral and multilateral funds.
ANNEX 4

18. The Global Programme Committee established a Programme Development Working Group consisting of the Directors of Programme Management in the six regional offices,¹ the Chairman of the Headquarters Programme Committee, a representative of the Director-General and a secretary, and requested it *inter alia* to develop in more detail an operational plan for WHO support in the next two years.

19. The Board was provided with information on the proposed Global Health Development Advisory Council, whose role was particularly to advise the Director-General on the best ways of ensuring multisectoral support for health for all and of monitoring progress towards its attainment. As indicated in the Director-General's progress report, most of the regions are in the process of setting up such councils or their equivalents. Also, many countries are strengthening their national advisory bodies by constituting health councils or their equivalents. The Board expressed certain reservations about the terms of reference of the proposed global council, some of which could be construed as encroaching on the activities of the Board itself. The Director-General explained that this was certainly not the intention; at the same time, he informed the Board that, in view of the reservations, he would proceed cautiously, and would seek the best forms of multisectoral consultation in as informal a manner as possible at this stage. He would keep the Board informed of developments.

20. The Board was informed of plans and steps taken to establish a Health/2000 Resources Group.² It was provided with information on the composition and functioning of such a group, which was tentatively scheduled to be convened at the beginning of May 1980. The Board expressed concern in general regarding the establishment of new groups, the risk of their over-proliferation and the potential duplication of the activities of other groups and of the Board. It was informed that this group would provide a mechanism for representatives of bilateral and multilateral agencies, developing countries and nongovernmental organizations to promote the rationalization of all health resources and stimulate the mobilization of resources for health. The Board approved the formation of this group and asked to be kept informed of its development and subsequent activities.

21. In the context of this discussion, the Board underlined the importance of improved correlation of its work with that of the regional committees and the Health Assembly. Only in this manner would the activities of the new groups established at regional and global levels contribute effectively to the implementation of regional and global health for all strategies.

IV. CRITICAL ISSUES

Political commitment

22. In reviewing the report of its Programme Committee on progress in formulating strategies for health for all by the year 2000, the Board expressed satisfaction with national progress reported as well as with the activities undertaken by the Secretariat in support of the formulation of national strategies. It particularly expressed appreciation of the many efforts undertaken to mobilize political commitment to health for all by the year 2000. The response and involvement of Heads of State attested to the changing awareness of the importance of health matters by political leaders. The adoption of resolution 34/58 by the United Nations General Assembly was further evidence of the recognition of the importance of the social target of health for all by the year 2000 by political leaders of all countries. At the same time, the Board expressed concern as to how best to exert greater influence to translate political commitment into real action. The next few years were seen as critical ones in this regard. Political commitment to the strategies at present being formulated would be placed in evidence by the development of broad declared governmental policies in support of health development and by significant increases in resources allocated for such development. Policies formulated would need to address the critical basic conditions which affected health, e.g. food, housing, agriculture and education, as well as other socioeconomic development factors which affected health development.

¹ In the Region of the Americas the functions of the Director of Programme Management are carried out by the Operations Manager.

² Document EB65/INF.DOC./3.
Specification of targets

23. The Board noted the particular importance of translating the general social goal of health for all by the year 2000 into meaningful operational targets at all levels. It affirmed that this social goal was an embodiment of the WHO constitutional objective of obtaining the highest attainable level of health of every human being. As such, the constitutional definition of health applied to the definition of health within the context of health for all by the year 2000. The specification of the year 2000 was an expression of the need on the part of all Member States to set operational targets which commit them to achieving social justice in health in the coming decades.

24. The Board noted the global and regional responsibility to encourage and stimulate Member States to define health for all by the year 2000 in a manner consistent with the WHO Constitution and the spirit of social justice underlying the Declaration of Alma-Ata. It recognized that all countries would need to formulate targets meeting their specific needs and to select indicators to assess progress towards reaching these targets.

25. In discussing the subject of indicators, the Board identified a number of attributes which the indicators should possess. At the same time it underlined the complexity of the problem of developing meaningful and measurable indicators which could capture the dynamic and continuous nature of health development. Broadly speaking, as countries progressed along the development continuum, the precise nature of the various factors and components contributing to health development changed, as well as the possibilities present for health development, both positively and negatively. In addition to these requirements, the Board felt that indicators related to political decision-making, the consequences of social and economic development for health, population expectations, and community involvement were also essential. Furthermore, attention should be given as to how best to identify areas where little or no progress was being made, e.g. the presence of high-risk groups whose size continues to grow.

26. The Board was informed of Secretariat activities undertaken to identify indicators of potential value for monitoring progress towards health for all. So far, the work carried out had concentrated mainly on two types of indicators considered relevant for monitoring progress: first, on those indicators for measuring health status and factors which could determine health status, such as the physical, social and economic environment, matters related to the quality of life, human behaviour, etc.; and, secondly, on those indicators for measuring the provision of and access to health care, namely, coverage by primary health care and relevant referral systems.

Obstacles recognized

27. The Board noted that most of the conditions and factors influencing health related to the need to improve social justice and equity within and among countries. Overcoming discriminatory action such as racism and apartheid was one dimension of the action that needed to be pursued through the mobilization of a political commitment in support of health for all. Also required was the reduction of international tensions through disarmament and détente, and the freeing of resources at present allocated to the military sector. The reported investments of US$ 25 000 million in military research and development work and the involvement of a quarter of the world's scientists and engineers in this area were a measure of the magnitude of the problem.

28. The Board recognized that not all economic developments contributed positively to health. Increased pollution, broken homes, and a deteriorating psychosocial environment were examples of the side effects of many national efforts to advance economic development without adequate social control. Restricted focus on the gross national product as the major indicator for development only further increased the possibility of serious side effects developing. In both industrialized and developing countries, health ministries often did not have the opportunity to analyse the potential health hazards associated with development projects. Significant increases in disease prevalence had been known to occur as a result of some agricultural development projects and, without general policies aimed at avoiding these and other ill effects of "development", individual initiatives by ministries of health could not be expected to have a high degree of success. The potential importance of United Nations General Assembly resolution 34/58 on "Health as an integral part of development" was noted in this context.
29. The Board identified a number of additional critical obstacles which national strategies would need to address. It recognized the inadequacy of the health infrastructure in the majority of countries to meet the challenges of primary health care. Obsolete health legislation, inadequate managerial and administrative practices and poor relations with the community, together with insufficient involvement of health professionals in primary health care, were cited as outstanding areas requiring reform. Only when such reform was forthcoming and tangible progress was achieved could one expect the population to begin to support and believe in primary health care. In this connexion the Board noted the importance of the discussions on the subjects of health legislation and the ongoing organizational study on the role of WHO in training in public health and health programme management, including the use of country health programming.

30. The Board stressed the importance of research as a means of solving the many problems inherent in the obstacles identified. Timely research undertaken in close correlation with the priority problems confronting the health services system could provide the health decision-makers with the information needed to guide the undertaking of necessary reforms. In this connexion, the Board noted the importance of the discussions on the development and coordination of biomedical and health services research (including research strengthening and career structures in developing countries).

Intersectoral collaboration

31. The Board recognized that many of the obstacles identified were associated with intersectoral collaboration - a highly important aspect of strategies required for the achievement of health for all by the year 2000. The need to collaborate with other sectors such as agriculture, education and labour was constantly reiterated in the discussions on nearly all the agenda items before the Board. It clearly represents one of the outstanding challenges before the Member States and the Organization. In adopting resolution EB65.R11 on formulating strategies for health for all by the year 2000 and resolution EB65.R12 on the study of WHO's structures in the light of its functions, the Board underlined the importance of this issue. One of the aims of resolution EB65.R11 is to encourage multisectoral action through a greater involvement of the whole United Nations system in health development; resolution EB65.R12 promotes intersectoral collaboration by encouraging the involvement of representatives of other sectors in the work of the governing bodies of the Organization.

32. In this connexion, the Board was particularly pleased to note the report of the UNIDO representative. It welcomed the interest shown by UNIDO in the Organization's work, and hoped that such links would be intensified. It noted with interest the growing cooperation focusing on industrial production policies and projects relating to pharmaceuticals and the utilization of natural resources. As one of the essential elements of primary health care, all efforts to strengthen national industrial capabilities for the production of essential drugs were to be commended.

WHO support

33. The Board discussed a number of areas where a strengthened WHO supporting role could help overcome obstacles identified. It noted that active steps should be taken not only to propagate the idea of health for all, but also to indicate practical measures to be taken in pursuit of that aim. The Board was of the opinion that it was insufficient for WHO to adopt a "wait-and-see" attitude. Representatives of WHO headquarters and regional offices needed to go into the field, see what is happening, engage in discussions and activities, and stimulate further action. High priority should be given to country health programming in support of strategy formulation, interagency cooperation for strengthening intersectoral planning of health, strengthening national mechanisms in support of health for all, such as national health councils and national health development centres and networks, and the development of guidelines on the organization of primary health care for use by administrators and trainers. In

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this context, the Board, while expressing general satisfaction with many of the meetings held in support of different aspects of strategy formulation, warned against the danger of attaching too much importance to them rather than to effective action.

34. The Board discussed the need for increased interregional exchanges to facilitate the formulation of strategies for health for all. In this regard, the development of regional charters and regional support to mechanisms for technical cooperation among developing countries (TCDC) were highlighted. The Board noted the responsibility of the Secretariat to ensure a wide distribution of national experiences at the same time as developing activities that fitted the needs of individual Member States. This responsibility was of particular importance in the light of the reaffirmed decision to formulate strategies first at national level, then at regional level, and lastly at global level.

V. FUTURE STEPS

35. In expressing satisfaction with the progress reported upon to date, the Board also expressed concern regarding the degree of real correlation between the reports of progress by all involved and the reality existing in countries. It noted its responsibility in determining whether or not such a gap exists. If developments are moving vigorously, then this momentum needs to be identified and reinforced. If they are not, then this too must be noted and corrective action must be taken accordingly.

36. The Thirty-third World Health Assembly was seen by the Board as a critical time to learn what was happening in the Member States. In this connexion the Board requested the Director-General and the Regional Directors to invite Member States to use the plenary of the Health Assembly to report upon selected critical aspects of national strategy formulation. This would reinforce the obligation of countries to report annually on progress achieved in improving the health of its people, as specified by Article 61 of the WHO Constitution; it would also be consistent with the Board's responsibility to call for additional information pertaining to health, as specified by Article 65.

37. The Board considered that work of the Secretariat regarding indicators was of immediate importance and that results should be distributed widely to stimulate discussions and exchange of views on this important item. The Secretariat need not wait for a further refinement. That was an area where considerable evolution could be expected as countries formulated and implemented their strategies. While there was a need to issue a draft without delay, no undue haste in finalizing such a list was called for.

38. The Executive Board adopted resolution EB65.R11 in response to resolution 34/58 on health as an integral part of development, adopted by the United Nations General Assembly on 29 November 1979. The Board realized the importance of this international demonstration of support for health goals, which clearly recognizes the integral place of health in development. The draft resolution recommended for adoption by the Thirty-third World Health Assembly called for action on the part of Member States and the Director-General which would respond to and take advantage of the United Nations General Assembly resolution, especially as regards encouraging multisectoral action with countries supported by the work of other international organizations having primary responsibilities in other sectors.1

39. In concluding the discussion on this item, the Board recognized that all strategies formulated would continue to evolve in response to the setbacks, successes, unforeseen developments, and emerging forces of which history is made. Nevertheless, the early specification of national strategies was of critical importance, the formulation of truly supportive regional and global strategies requiring the formulation of national strategies that reflect fully the results of Alma-Ata.

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1 The Director-General submitted to the Health Assembly, in document A33/29, an account of the action he had taken to enhance the collaboration between WHO and other organizations within the United Nations system in support of United Nations General Assembly resolution 34/58.
Appendix

TEXT OF UNITED NATIONS GENERAL ASSEMBLY RESOLUTION 34/58

Health as an Integral Part of Development

The General Assembly,

Recalling its resolutions 3201 (S-VI) and 3202 (S-VI) of 1 May 1974, containing the Declaration and the Programme of Action on the Establishment of a New International Economic Order, 3281 (XXIX) of 12 December 1974, containing the Charter of Economic Rights and Duties of States, and 3362 (S-VII) of 16 September 1975 on development and international economic co-operation,

Recalling also the United Nations conferences held in recent years on major issues relating to economic and social development and the establishment of the new international economic order, particularly the International Conference on Primary Health Care, jointly sponsored by the World Health Organization and the United Nations Children's Fund, held at Alma Ata, Union of Soviet Socialist Republics, from 6 to 12 September 1978,

Noting that a substantial portion of the population in many countries, developing as well as developed, lacks access to basic health services, and that people lacking adequate health cannot fully participate in or contribute to the economic and social development of their nation,

Welcoming the important efforts of the World Health Organization, the United Nations Children's Fund and the other agencies of the United Nations system associated with the effort to attain the goal of health for all by the year 2000, as expressed in World Health Assembly resolutions WHA30.43 of 19 May 1977 and WHA32.30 of 25 May 1979,

Considering that peace and security are important for the preservation and improvement of the health of all people and that co-operation among nations on vital health issues can contribute importantly to peace,

Cognizant of the vital role that health and health care play in the development of countries, particularly developing countries,

1. Endorses the Declaration of Alma Ata,1 in particular the view that primary health care, aimed at the solution of the major world health problems through a combination of promotive, preventive, curative and rehabilitative measures, constitutes the key to the ultimate achievement of a healthful society, especially when primary health care is incorporated into the development process, particularly that of developing countries;

2. Notes with approval the decision of the World Health Assembly, contained in resolution WHA32.30, that the development of the programmes of the World Health Organization and the allocation of its resources at the global, regional and country levels should reflect the commitment of that organization to the priority of the achievement of health for all by the year 2000;

3. Calls upon the relevant bodies of the United Nations system to co-ordinate with and support the efforts of the World Health Organization by appropriate actions within their respective spheres of competence;

4. Appeals to Member States to carry out the actions called for in the Declaration of Alma Ata;

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1 E/ICEF/L.1387, annex, sect. V.
5. **Reiterates** the appeal contained in paragraph 10 of World Health Assembly resolution WHA32.30 to the international community to give full support to the formulation and implementation of national, regional and global strategies for achieving an acceptable level of health for all;

6. **Welcomes** the decision of the World Health Assembly to ensure that the global strategy shall be reflected in the contribution of the World Health Organization to the preparation of the international development strategy for the third United Nations development decade and calls upon the Preparatory Committee for the New International Development Strategy to give full and careful attention to the contribution of the World Health Organization;

7. **Calls upon** Member States, both developed countries and developing, to co-operate with each other and with the World Health Organization in the exchange of technological information and expertise in order to facilitate the achievement of the primary health care goals;

8. **Requests** the Director-General of the World Health Organization, after the sixty-seventh session of the Executive Board of the World Health Organization and the Thirty-fourth World Health Assembly, to submit a report to the Economic and Social Council, at the appropriate session of 1981, on the progress achieved in the formulation of the global health strategy and calls upon the Council, in turn, to submit recommendations for further action by the General Assembly at its thirty-sixth session.

82nd plenary meeting
29 November 1979
1. After the adoption of the International Health Regulations (1969), the Governments of Egypt, India and Pakistan made certain reservations that were accepted by the Twenty-third World Health Assembly in accordance with Article 95, paragraph 1, of the Regulations, which reads as follows:

If any State makes a reservation to these Regulations, such reservation shall not be valid unless it is accepted by the World Health Assembly, and these Regulations shall not enter into force with respect to that State until such reservation has been accepted by the Assembly or, if the Assembly objects to it on the ground that it substantially detracts from the character and purpose of these Regulations, until it has been withdrawn.

Some of these reservations were, however, accepted only for a period of three years, which was subsequently renewed by the Twenty-sixth World Health Assembly and the Thirtieth World Health Assembly.

2. These reservations expired on 31 December 1979. By letters of 24 September 1979 from Egypt, 18 September 1979 from India and 27 October 1979 from Pakistan, these three Member States indicated the wish to have their reservations further extended (see correspondence reproduced in Appendices 1-3).

3. The members of the WHO Expert Advisory Panel on International Surveillance of Communicable Diseases have been consulted with respect to the requests for the extension of the reservations concerned and recommend their acceptance.

4. The existence of these reservations has caused no difficulty in the administration of the International Health Regulations in regard to their stated purpose. In view of the fact that they have been previously accepted for a three-year period on three occasions, it is believed that the experience gained would now allow them to be extended without time-limit, as is the situation for a number of other reservations both for the countries concerned and for other countries.

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1 See resolution WHA33.29.
4 WHO Official Records, No. 240, 1977, resolution WHA30.19 and Annex 1, section B.
Appendix 1

EGYPT

(a) Letter, dated 20 June 1979, from the Director-General of WHO to the Minister of Health, Cairo

I have the honour to refer to the reservations of your Government to the International Health Regulations (1969) adopted by the Twenty-second World Health Assembly (resolution WHA22.46) and amended by the Twenty-sixth World Health Assembly (resolution WHA26.55).

As you will recall, in your letter of 3 May 1977, your Government has made the following reservations to Article 3, paragraph 1, and Article 4, paragraph 1:

"The Government of Egypt reserves the right to consider the whole territory of a country as infected with yellow fever whenever yellow fever has been notified under Article 3, paragraph 1, or Article 4, paragraph 1."

These reservations remain effective until 31 December 1979. It would be very much appreciated if you could inform us whether your Government considers that these reservations may now expire at the end of the period for which they were accepted by the World Health Assembly.

I should be grateful if you could advise me by the end of September of the present position of your Government. The reservations, if any, will subsequently be put before the Thirty-third World Health Assembly which will take the final decision regarding their acceptance.

(b) Letter, dated 24 September 1979, from the Director-General, Foreign Health Relations Department, Ministry of Health, Cairo, to the WHO Regional Director for the Eastern Mediterranean (translation from the Arabic)

I wish to refer to WHO Geneva letter No. ESD-14/439/2 (5) dated 20 June 1979 in connexion with the reservations of the Arab Republic of Egypt to Article 3, paragraph 1, and Article 4, paragraph 1 of the International Health Regulations, which remain effective until 31 December 1979. These reservations read as follows:

"The Government of Egypt reserves the right to consider the whole territory of a country as infected with yellow fever whenever yellow fever has been notified under Article 3, paragraph 1, or Article 4, paragraph 1."

The Ministry of Health is agreeable to maintaining the above reservations in respect of yellow fever, and would like to extend them for a further period.

It would be appreciated if WHO Geneva could be notified accordingly.

Appendix 2

INDIA

(a) Letter, dated 20 June 1979, from the Director-General of WHO to the Minister of Health and Family Welfare, New Delhi

I have the honour to refer to the reservations of your Government to the International Health Regulations (1969) adopted by the Twenty-second World Health Assembly (resolution WHA22.46) and amended by the Twenty-sixth World Health Assembly (resolution WHA26.55).
Three of these reservations, the text of which is reproduced in the annex to this letter, remain effective until 31 December 1979. It would be very much appreciated if you could inform me in due time whether your Government considers that those reservations which are effective for a limited period of time may now expire at the end of that period and whether your Government feels able to withdraw the reservations to Articles 44 and 88.

I should be grateful if you could advise me by the end of September of the present position of your Government.

The reservations, if any, will subsequently be put before the Thirty-third World Health Assembly which will take the final decision regarding the acceptance of any reservations in accordance with Article 95 of the International Health Regulations (1969).

Reservations of India to the International Health Regulations (1969)

I. Reservations effective until 31 December 1979:

Article 3, paragraph 1, and Article 4, paragraph 1

The Government of India reserves the right to consider the whole territory of a country as infected with yellow fever whenever yellow fever has been notified under Article 3, paragraph 1, or Article 4, paragraph 1.

Article 7, paragraph 2(b)

The Government of India reserves the right to continue to regard an area as infected with yellow fever until there is definite evidence that yellow fever infection has been completely eradicated from that area.

Article 43

The Government of India reserves the right immediately to disinsect on arrival an aircraft which, on its voyage over infected territory, has landed at a sanitary airport which is not itself an infected area, if an unprotected person from the surrounding infected area has boarded the aircraft and if the aircraft reaches India within a period during which such a person is likely to spread yellow fever infection.

This reservation will not apply to aircraft fitted with an approved vapour disinsecting system which is compulsorily operated.

II. Reservations accepted without time-limit:

Article 44

The Government of India reserves the right to apply the terms of Article 69 to the passengers and crew on board an aircraft landing in the territory of India who have come in transit through an airport situated in a yellow-fever infected area, not equipped with a direct transit area.

Article 88

The Government of India shall have the right to require of persons on an international voyage arriving by air in its territory or landing there in transit, but falling under the terms of paragraph 1 of Article 70, information on their movements during the last six days prior to disembarkation.

1 The Government of India was requested by the Twenty-sixth World Health Assembly to reconsider its position with regard to this reservation.
Letter, dated 18 September 1979, from the Deputy Secretary to the Government of India, Ministry of Health and Family Welfare, New Delhi, to the Director-General of WHO

Subject: International Health Regulations (1969) - Reservations effective until 31 December 1979

I am directed to refer to your letter No. ESD-14/439/2 (5), dated 20 June 1979, on the subject mentioned above, and to say that the Government of India considers it necessary to seek extension of the three existing reservations to the International Health Regulations 1969 viz., (i) Article 3, paragraph 1 and Article 4, paragraph 1, (ii) Article 7, paragraph 2(b) and (iii) Article 43, for a period of three years beyond 31 December 1979. It is also considered necessary that reservations to Articles 44 and 88 should continue to be in force.

Appendix 3

PAKISTAN

Letter, dated 20 June 1979, from the Director-General of WHO to the Director-General of Health and Joint Secretary (ex officio) to the Government of Pakistan, Ministry of Health, Social Welfare and Population Planning, Islamabad

I have the honour to refer to the reservations of your Government to the International Health Regulations (1969) adopted by the Twenty-second World Health Assembly (resolution WHA22.46) and amended by the Twenty-sixth World Health Assembly (resolution WHA26.55).

Four of these reservations, the text of which is reproduced in the annex to this letter, remain effective until 31 December 1979. It would be very much appreciated if you could inform me in due time whether your Government considers that those reservations which are effective for a limited period of time may now expire at the end of that period and whether your Government feels able to withdraw the reservation to Article 44.

I should be grateful if you would advise me by the end of September of the present position of your Government.

The reservations, if any, will subsequently be put before the Thirty-third World Health Assembly which will take the final decision regarding the acceptance of any reservations in accordance with Article 95 of the International Health Regulations (1969).

Reservations of Pakistan to the International Health Regulations (1969)

I. Reservations effective until 31 December 1979:

Article 3, paragraph 1, and Article 4, paragraph 1

The Government of Pakistan reserves the right to consider the whole territory of a country as infected with yellow fever whenever yellow fever has been notified under Article 3, paragraph 1, or Article 4, paragraph 1.

Article 7, paragraph 2(b)

The Government of Pakistan reserves the right to continue to regard an area as infected with yellow fever until there is definite evidence that yellow fever infection has been completely eradicated from that area.

Article 43

The Government of Pakistan reserves the right to disinsect immediately on arrival an aircraft which, on its voyage over infected territory, has landed at a sanitary airport which is not itself an infected area.
This reservation will not apply to aircraft fitted with an approved vapour disinsecting system which is compulsorily operated.

Article 88

The Government of Pakistan shall have the right to require of persons on an international voyage arriving by air in its territory or landing there in transit, but falling under the terms of paragraph 1 of Article 70, information on their movements during the last six days prior to disembarkation.

II. Reservation accepted without time-limit:

Article 44

The Government of Pakistan reserves the right to apply the terms of Article 69 to the passengers and crew on board an aircraft landing in the territory of Pakistan who have come in transit through any airport situated in a yellow-fever infected area, not equipped with a direct transit area.

(b) Letter, dated 27 October 1979, from the Assistant Director-General of Health, Ministry of Health and Social Welfare (Health and Social Welfare Division), Islamabad, to the Director-General of WHO

Subject: Reservations of our Government to the International Health Regulations (1969) adopted by the Twenty-second World Health Assembly

I am directed to refer to your letter No. ESD-4/439/2 (5), dated 20 June 1979, on the subject mentioned above and to supply the following information as desired:

Due to potential danger of spread of yellow fever in Pakistan it has been decided that all precautions and strict vigilance should be continued to apply the reservation as before.
ANNEX 6

FOLLOW-UP OF WHO/UNICEF MEETING ON INFANT AND YOUNG CHILD FEEDING

Report by the Director-General

I. Introduction

1. The joint WHO/UNICEF Meeting on Infant and Young Child Feeding, which was held from 9 to 12 October 1979, was part of the two organizations' programmes for the promotion of child health and nutrition, which form important elements in primary health care and in the activities for the International Year of the Child. It was attended by a total of some 150 representatives of governments, the United Nations specialized agencies, nongovernmental organizations and the infant-food industry, and scientists. The Meeting had as its objective to discuss and summarize the current state of knowledge concerning appropriate infant and young child nutrition, the social, health and environmental factors affecting it, contemporary trends in feeding practices, the factors contributing to them and their implications for future action.

2. The work of the Meeting was conducted in plenary session and in five working groups. There was one background document prepared by WHO and UNICEF (document FHE/ICF/79.3), which reviewed current information, including certain of the results of the first phase of the WHO collaborative study on breastfeeding carried out in nine countries. The working groups examined the following themes, which formed the basis for the Meeting's recommendations and are also taken up in the sections of part II below: encouragement and support of breastfeeding; promotion and support of appropriate weaning practices; information, education, communication and training; health and social status of women in relation to infant and young child feeding; appropriate marketing and distribution of breastmilk substitutes.

3. The statement and recommendations of the Meeting were attached to the report of the Programme Committee of the Executive Board, "Formulating strategies for health for all by the year 2000: progress report", as an example of activities being undertaken by the Organization that are directed towards the goal of health for all by the year 2000.

4. The subjects considered at the Meeting and its recommendations are of such importance that they should be given high priority in the formulation of national programmes and in national strategies for health for all by the year 2000. They are an important part of WHO's programme of family health, including as it does activities in maternal and child health, nutrition and health education as recommended by recent Health Assembly resolutions, particularly resolutions WHA31.55 on maternal and child health, WHA32.42 on the long-term programme for maternal and child health, and WHA31.47 on nutrition (the role of the health sector in the development of national and international food and nutrition policies and plans).

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1 See resolution WHA33.32.

2 Document EB65/4. The statement and recommendations are appended (p. 118); the subsequent progress report of the Executive Board is reproduced as Annex 4 in this volume (p. 98).

3 Document WHA31/1979/REC/1, p. 39.
5. In the follow-up of the recommendations it may be appropriate for governments to undertake studies and define the situation in their own countries so as to formulate better policies and programmes concerning infant and young child feeding and to develop national legislation and machinery for the regulation and monitoring of the marketing of breastmilk substitutes; the draft international code of marketing practices (see paragraphs 26-31 below) could be used as a basis for this action.

II. Follow-up activities already undertaken or planned

6. The statement and recommendations adopted by the Meeting have been made available in Arabic, English, French, Russian and Spanish and have been widely distributed by WHO to all Member States, governmental bilateral agencies, WHO regional offices, WHO programme coordinators and field staff; and by UNICEF to all staff at country level; copies were also sent to a large number of nongovernmental organizations, to participants in the Meeting, medical schools, schools of public health, professional journals and associations and WHO expert panel members and collaborating centres.

7. For ease of reference, follow-up activities have been grouped in this report under the themes treated by the working groups, which are also the subjects of the recommendations as they appear in the Appendix.

The encouragement and support of breastfeeding

8. In the African Region, as part of the follow-up to the WHO collaborative study on breastfeeding, an intersectoral workshop on breastfeeding was held in Nigeria in November 1979 in collaboration with the Nigerian Commission for the International Year of the Child (IYC) and representatives of the IYC commissions of Ghana, the Gambia and Liberia. Similar workshops were held in Zaire, also in November, with representatives of different government sectors and international agencies. Also, a regional programme was developed for collaboration in the development of national projects for the improvement of infant and young child feeding, with the aim of safeguarding breastfeeding and ensuring the better use of local foods during the weaning period. Projects are already in operation in Angola, Ethiopia, Madagascar, Nigeria, Senegal and Sierra Leone.

9. In the Americas the Regional Office has assisted greatly in giving the statement and recommendations wide distribution amongst national authorities; and a subregional workshop has been arranged for Central American countries in Honduras in March 1980. Educational workshops are to take place in Chile and Colombia.

10. In the Eastern Mediterranean Region prevalence studies of breastfeeding are being undertaken. A travelling seminar on oral rehydration and breastfeeding was held in December 1979 and a regional scientific working group on breastfeeding is being established in 1980.

11. In the European Region, a meeting on infant and young child feeding was organized in December 1979 in collaboration with the Swedish Board of Health and Welfare. The meeting, which was a follow-up to the WHO collaborative study, involved the Ministry of Commerce, professional experts, nongovernmental organizations in Sweden, and the Swedish infant-food industry. As a result of the meeting, the Director-General of the Swedish Board of Health and Welfare agreed to form a task force in Sweden to examine the question of guidelines for the export of infant foods and on infant-food technology.

12. In the South-East Asia Region consultations have been arranged with countries for the collection of data on breastfeeding. On the basis of the findings a simplified version of the protocol of the WHO collaborative study will be tested for its wider application in the Region.

13. Information from studies in some countries in the Western Pacific Region is being collected in order to identify areas that require further study. A workshop has been arranged in Hong Kong for June 1980.

14. WHO and the International Paediatric Association will hold a workshop in Barcelona, Spain, on 7-8 September 1980, on "Nutrition during pregnancy and the health of the offspring". There will be about 50 participants with representation from all WHO regions.
15. The WHO/UNICEF Meeting highlighted the problems of infants who cannot - for whatever reason - be breastfed; a statement on the dietary management of young infants who are not adequately breastfed is being prepared within the framework of the United Nations system by the Consultative Group on Maternal and Child Nutrition of the ACC Sub-Committee on Nutrition.

Promotion and support of appropriate and timely complementary feeding (weaning) practices with the use of local food resources

16. The WHO/UNICEF Meeting recognized that "food complementary to breastmilk will need to be introduced by the age of four to six months; when the nutrition of the mother is poor and/or environmental conditions are unfavourable, it may often need to be introduced earlier". It was requested that further research and scientific meetings be held on this matter, and therefore the above-mentioned consultative group of the ACC Sub-Committee on Nutrition is organizing a scientific meeting at WHO headquarters in early September 1980. A review of the literature is being prepared as background information, and persons with specialized knowledge and data will be invited to participate. It is expected that recommendations will be produced on the most appropriate time for and ways of complementing breastfeeding under different circumstances.

17. As part of the development of the action-oriented research development and research training programme on nutrition,1 emphasis is given to the promotion of adequate weaning practices. Research has been initiated into local customs and beliefs as well as means for the better utilization of foods that are normally available to communities and which do not involve high expense or dependence upon external resources. Based on the knowledge gained from this, studies will be undertaken of how best to apply this technology in activities forming part of primary health care.

18. The data from these studies, as well as others, will help to provide more insight into the question of the biological needs of mothers for adequate breastfeeding, and will provide, together with the data on volume and composition of breastmilk (which forms the second phase of the WHO collaborative study on breastfeeding), the basis for a scientific review of this important issue.

19. WHO and the International Children's Centre will organize a symposium in Paris from 15 to 17 September 1980 to be entitled "The Nathalie Masse international symposium on human growth and development in the postnatal period", which will include discussions on infant and young child feeding. There will be about 50 participants, with representation of all WHO regions.

Strengthening of education, training and information on infant and young child feeding

20. Workshops on infant and young child feeding have been organized for policy-makers from different sectors in Nigeria, Sweden and Zaire. Each of these countries had participated in the WHO collaborative study and, in addition to the recommendations of the WHO/UNICEF Meeting, data from the study were used as a basis for the workshop discussions. Similar activities are planned for 1980 in Chile, Colombia, Ethiopia, Hong Kong, Hungary, the Philippines and, for the Central American region as a whole, in Honduras. National workshops are also planned for the Caribbean countries that participated in the PAHO/WHO Caribbean Food and Nutrition Institute technical group meeting on breastfeeding in 1979 in Barbados - those in Antigua and St Lucia have already taken place.

21. In order to facilitate the organization of further, similar educational activities, various materials are being developed. They will provide information on the nutritional, immunological, and psychological and emotional functions of breastfeeding and those related to reproductive function, as well as suggestions for action to promote and facilitate sound feeding practices, and are intended to provide a consistent message on infant and young child feeding. The materials include slides with sound-recording, and will give details of the social and physiological needs of mothers and the ways in which these needs can be met.

1 The programme has been developed in accordance with the provisions of resolution WHA31.47, and has been endorsed by the global and regional advisory committees on medical research.
They will be complemented by a brochure on breastfeeding which has been produced for primary health workers, and educational posters on breastfeeding now being prepared for use in health and training institutions. The educational materials are to be provided at low cost and given wide distribution.

22. Because the training of health workers has not always included comprehensive and up-to-date information on the different aspects of breastfeeding, a teaching module is also being prepared for use by the trainers of health workers. The module is designed in such a way as to permit local adaptation to the needs of different levels of health workers and for use by instructors with a broad range of students.

23. In order to allow national policy-makers and organizers of educational programmes to base them on national data, the protocol of the WHO collaborative study is being simplified to allow for easier implementation and permit a rapid feedback of data on prevalence and duration. The protocol will include suggestions for sampling methods, data analysis, interviewer selection and training.

24. Institutions in Guatemala, Hungary, the Philippines, Sweden and Zaire are continuing the second phase of the WHO collaborative study, on volume and composition of breastmilk. In all the studies the milk sample collection phase has been completed, except in Nigeria, where the study is of a longitudinal nature, and where sample collection will continue for 18 months. A workshop is planned for the second half of 1980, to review results. This is complementary to the action-oriented programme mentioned above.

Development of support for improved health and social status of women in relation to infant and young child feeding

25. With regard to the status of women and young child feeding, steps have been taken to incorporate this information into the background materials for the World Conference of the United Nations Decade for Women, to be held in Copenhagen in July 1980. The WHO background paper in particular emphasizes the need for measures to support women as part of measures to encourage breastfeeding. The report of the WHO/UNICEF Meeting is to be distributed at the Conference, and the recommendations are to be given consideration in the formulation of the programme of action for the second half of the Decade from 1980 to 1985.

Appropriate marketing and distribution of infant formula and weaning foods

26. The WHO/UNICEF Meeting recommended "that there should be an international code of marketing of infant formula and other products used as breastmilk substitutes". The statement continued: "This should be supported by both exporting and importing countries and observed by all manufacturers. WHO/UNICEF are requested to organize the process for its preparation, with the involvement of all concerned parties, in order to reach a conclusion as soon as possible".

27. A preliminary draft of an international code of marketing of infant formula and other products used as breastmilk substitutes has been prepared as requested. This first draft has been sent to all governments under cover of a circular letter, reference C.L.2.1980 dated 20 February 1980, with a request that comments and observations on the document should be received by the Director-General by 31 March 1980.

28. A series of five consultations have also been held with all interested parties including the specialized agencies in the United Nations system, nongovernmental organizations and professional associations, experts, and the industry, on the format and content of the draft code.

29. As a result of the comments and suggestions received, a further draft of the code is being prepared and will be available to the Thirty-third World Health Assembly."

1 The draft code was submitted as an addendum to this report.
30. The work of the Codex Alimentarius Commission related to infant foods is being taken into consideration in the preparation of this international code of marketing for breastmilk substitutes, and there is close coordination with the Commission to ensure complementarity of action and prevent duplication.

31. The advice of the Thirty-third World Health Assembly is sought specifically in relation to the implementation of the recommendations of the WHO/UNICEF Meeting and the further development of follow-up activities, particularly the further development of the draft international code of marketing practices and its implementation.

Appendix

STATEMENT AND RECOMMENDATIONS OF THE
JOINT WHO/UNICEF MEETING ON INFANT AND YOUNG CHILD FEEDING
GENEVA, 9-12 OCTOBER 1979

Statement on Infant and Young Child Feeding

The joint WHO/UNICEF Meeting on Infant and Young Child Feeding, which was held at WHO in Geneva from 9 to 12 October 1979, in expressing the need for urgent action by governments, international agencies, nongovernmental organizations and the infant-food industry and health and development workers to promote the health and nutrition of infants and young children, made the following statement:

1. Poor infant-feeding practices and their consequences are one of the world's major problems and a serious obstacle to social and economic development. Being to a great extent a man-made problem it must be considered a reproach to our science and technology and our social and economic structures, and a blot on our so-called development achievements. It is not only a problem of the developing world: it occurs in many parts of the developed world as well.

2. The question of adequate nutrition for mankind has been exercising international and national bodies for the last three decades, but the problem of malnutrition is not becoming less. It is taking a heavy toll in deaths and in long-term mental and physical disability. Women, with infants and young children, are its chief sufferers. This is socially, economically and politically unacceptable.

3. In this International Year of the Child, national governments and the international community are being called upon to focus on this complex problem and to take steps to ensure that children everywhere get a proper start in life on the basis of, inter alia, adequate nutrition. Governments and local communities have a major role to play in supporting action aimed at mothers and children to ensure sound infant and young child feeding practices.

4. Malnutrition in infants and young children cannot be separated from malnutrition and poor health in women. The mother and her infant form a biological unit; they share also the problems of malnutrition and ill-health, and whatever is done to solve these problems must concern them both together.

5. The problem is part of the wider issues of poverty, lack of resources, social injustice and ecological degradation; it cannot be considered apart from social and economic development and the need for a new international economic order. It is also a basic issue for health care systems and its solution must be seen in the context of health for all by the year 2000.

6. The WHO/UNICEF Meeting on Infant and Young Child Feeding affirms the right of every child and every pregnant and lactating mother to be adequately nourished as a means of attaining and maintaining physical and psychological health. It stresses the responsibility of every society to ensure the effective enjoyment of this right so that children may develop to their full potential.
7. Breastfeeding is an integral part of the reproductive process, the natural and ideal way of feeding the infant and a unique biological and emotional basis for child development. This, together with its other important effects, on the prevention of infections, on the health and well-being of the mother, on child spacing, on family health, on family and national economics, and on food production, makes it a key aspect of self-reliance, primary health care and current development approaches. It is therefore a responsibility of society to promote breastfeeding and to protect pregnant and lactating mothers from any influences that could disrupt it.

8. The period of weaning from the breast is a critical stage which often results in malnutrition and disease if the child does not have a diet that is adequate in quantity and quality, hygienically prepared and culturally, socially and economically acceptable.

9. The health of infants and young children cannot be isolated from the status of women and their roles as mothers and as partners in social and economic development. In poor urban and rural communities where the health and socioeconomic status of women is deteriorating, a corresponding deterioration is taking place in the health of infants and young children.

10. Health for all cannot be attained unless there is a substantial improvement in the socioeconomic condition of women, the particular needs of mothers and their infants and young children are recognized and met, and conditions are provided that promote and sustain the well-being of the family. These conditions include the right of women to information and education that will enable them to improve their own health and that of their families and to take an active part in decision-making on matters that affect their own and their children's health. They include also attention to the role of fathers in providing for the needs of their family.

11. The production, preservation, processing and distribution of food are essential components of any approach to ensuring the proper feeding of families and children. Emphasis should be placed on fresh local foods and traditional practices, complemented only when necessary, and under the guidance of government, by industrially processed products.

12. The WHO/UNICEF Meeting on Infant and Young Child Feeding affirms the need for sustained national and international action, and for the active participation of families, and especially mothers, in the elimination of malnutrition and the promotion of health. This is a challenge to all social and economic development strategies and to the world community as a whole. In the International Year of the Child it is fitting that national and international efforts be intensified, and that the enthusiasm it has generated in the cause of child health be sustained, to respond to this challenge.

Recommendations

THE ENCOURAGEMENT AND SUPPORT OF BREASTFEEDING

Health care system

Because of the fundamental importance of the health of the mother for breastfeeding, which in turn is essential for the health and development of the infant, and because health services through the primary health care approach, especially where they relate to the health of mothers and children, have an important preventive role to play, it is recommended:

During pregnancy

Every attempt should be made to ensure the sound nutritional status of women and that their nutritional and health needs are met, especially during pregnancy. The health care system, in collaboration with other sectors, should help in identifying and utilizing existing local resources so as to ensure that the nutritional needs of the mothers are met.
The health care system in general should ensure that all mothers, particularly during the period of pregnancy, are systematically provided with the type of breastfeeding education that is in keeping with their life situations and presented in practical ways that are likely to enhance their understanding and acceptance of it.

Emphasis should be given to the fact that lactation is a natural biological process but that to some extent breastfeeding is an act which must be anticipated and reinforced. With adequate teaching and support almost all mothers are capable of breastfeeding and solving any problems which may arise. The best teachers will be breastfeeding mothers.

During pregnancy information and guidance should be provided to all mothers concerning preparation for breastfeeding and ways in which they can establish and maintain breastfeeding. The full cooperation of women's groups and other bodies working for the promotion of breastfeeding should be sought and supported by the health care system.

Attention should be given to ensuring that, wherever possible, all health workers in a position to provide adequate information to the mother on breastfeeding should be committed to the promotion of breastfeeding and have a thorough knowledge of its management.

Care should be given during the pregnancy period to identifying those mothers who are likely to be, because of their special social, economic or health condition, at high risk of not breastfeeding, and special care should be given to them so as to enhance improvement of their situation and the establishment of breastfeeding.

**Delivery**

Obstetrical procedures and practices should be consistent with the policy of promoting and supporting breastfeeding. In this respect, unnecessary sedation, routine use of episiotomy, and routine use of lactation suppressants should be avoided.

Breastfeeding should be initiated as soon after birth as possible, normally during the first half hour, and in order to facilitate breastfeeding, mothers should be permitted and encouraged to keep their infants with them in the same room or close to them and to practise on-demand feeding; maternity routines and structures should be conducive to this practice.

Health-related staff, including traditional birth attendants, should seek to provide mothers not only with educational information but also with practical help and should be provided with appropriate information on the preparation for and management of breastfeeding.

The role of the father and other members of the extended family in providing support for the mother should be emphasized in all prenatal, maternity and postnatal care, and fathers should be invited to participate actively with the health team in encouraging the mother to breastfeed.

**After delivery**

All postnatal health care should be oriented towards ensuring the maintenance of breastfeeding for as long as possible. All babies should receive colostrum. For optimal breastfeeding, the use of supplementary bottle feeding - water and formula - should be avoided. A healthy well-nourished mother who is fully breastfeeding her infant should not need to introduce any complements until after the first four to six months of life, according to the needs of the infant.

Mothers' nutritional status should be reviewed and, whenever possible, steps taken to ensure that the mother has access to adequate food intake.

The contraceptive effect of breastfeeding should be well recognized, although additional family planning methods should be promoted to ensure birth spacing. Preference should be given to contraceptive methods which do not interfere with the normal process of lactation.
All attempts should be made to ensure that in cases where infants need to be hospitalized facilities are provided so that the mother can be with the infant and continue breastfeeding or that the baby can continue to receive breastmilk.

Where it is not possible for the biological mother to breastfeed, the first alternative, if available, should be the use of human breastmilk from other sources. Human milk banks should be made available in appropriate situations.

The terms "humanized" and "maternalized" milk for infant formula should be avoided.

**Support through the health services**

Health service staff must play a critical role in the initiation, establishment and maintenance of breastfeeding and should ensure that the mother has a source of sustained support for as long as breastfeeding continues, and thus health workers should be well informed and provide consistent information.

A baby who is not breastfed should receive special attention from the health care system. Adequate instructions for the use of infant foods as well as warnings about its problems should be the responsibility of the health care system. Supplies of infant formula would thus be required for distribution only where necessary and not as a routine.

**Employed mothers**

Paid maternity leave of not less than three months postnatal, job security and economic support should be provided to all mothers whenever possible, and wherever possible, and the responsibility for economic support during maternity leave should be carried by the government, the industry in which the woman is working, and other relevant international and national institutions.

Crèches, paid breastfeeding breaks and other facilities should be provided, wherever appropriate, in industry and in other relevant institutions, or close to the place of work, to permit mothers to continue breastfeeding and have close contact with their babies. Financing of crèches and other mechanisms that allow for this continued contact of breastfeeding should be carried by the government and/or the industry in which the mother is working.

**Community and government support**

All channels of communication, including religious leaders, school-teachers and other community opinion leaders and voluntary associations, particularly women's organizations, should be actively involved, together with health services and other sectors, in encouraging and supporting breastfeeding and sensitizing the community to the value of breastfeeding and the needs of the mother and baby through home visits, if necessary.

Messages concerning infant and young child feeding should be consistent from one sector to another and from one population group to another and, therefore, the promotion of breastfeeding and appropriate infant and young child feeding practices in general should be set within the context of overall maternal and child health practices, national nutrition policies and primary health care.

Governments should be encouraged to set up national expert groups to advise them on policies about breastfeeding and to establish coordinating offices that can ensure consistency and continuation of supportive activities and implementation of ongoing evaluation and monitoring as well as systematic epidemiological research including social factors.

WHO, UNICEF and other organizations should be responsible for encouraging regional and national workshops for the promotion of appropriate infant and young child feeding.
Food complementary to breastmilk will need to be introduced by the age of four to six months; when the nutrition of the mother is poor and/or environmental conditions are unfavourable, it may often need to be introduced earlier. However, too early introduction of supplements may have a negative effect on breastfeeding and may also increase the risk of infection.

The diet of the young child after cessation of breastfeeding needs special attention, because inadequate feeding at this time often leads to clinical forms of malnutrition, particularly when the child is denied the breast as a consequence of a new pregnancy.

In order to guide the mother as to the adequacy of her child's nutrition and the appropriate time to introduce weaning foods, programmes to support her in keeping a graph of her infant's weight and to understand its significance should be extended as widely as possible. The WHO publication "A growth chart for international use in maternal and child health care" provides valuable guidance for doing so.

Foods that are locally available in the home can be made suitable for weaning and their use should be strongly emphasized in health education and agricultural extension programmes. Foods traditionally given to infants and young children in some populations are often deficient in nutritional value and hygiene, and need to be improved in various ways. Mothers need guidance to improve these traditional foods through combinations with other foods available to them locally. Countries should determine the need for subsidizing weaning foods or otherwise helping to ensure their availability to low-income groups.

Governments and relevant public or private organizations should support practical and appropriate initiatives and policies for improving the nutritional value and hygienic standards of traditional and other locally used weaning foods, for achieving a balanced diet for infants, for educating mothers in the proper feeding of children, and for facilitating the exchange of weaning and child-feeding experiences among countries.

To avoid infection and interference with continued breastfeeding, infants during weaning should not be fed by bottle but rather by cup and spoon or other suitable traditional vessels and utensils. When mothers do not initiate breastfeeding, or terminate it prematurely, so that animal milk or perhaps vegetable milk mixtures or products may need to be fed by bottle, competent guidance should be available to the individual mothers to ensure that the mixture or product fed is nutritionally adequate, both in quantity and quality, and that all possible measures are taken to see that it does not become a vehicle for infection.

Psychological, social and economic factors that constrain breastfeeding should be minimized.

These questions should be the subject of further research and subsequent scientific meetings.

STRENGTHENING OF EDUCATION, TRAINING AND INFORMATION ON INFANT AND YOUNG CHILD FEEDING

Every citizen has the right to have access to correct, consistent information and education; therefore, countries must ensure that information and education are provided to all levels and that the messages reach those for whom they are intended at community, intermediate and central levels.

In all educational (formal and non-formal), vocational and professional training programmes, the interrelationship of all knowledge relating to health protection, breastfeeding and adequate nutrition of the mother, infant, and child should be featured.

To ensure maximal effectiveness, educational and informational activities about nutrition must:

- be adapted to local conditions and culture;
- be directed to the target population, including men — viz. schoolchildren, youth, pregnant and breastfeeding mothers, community leaders, decision-makers and planners;

- be supported by necessary resources from those sectors responsible for periurban and rural economic development;

- be undertaken with the active participation of husbands, other family members, and community leaders;

- be linked to measures for income-generation at family and community level;

- utilize local cultural methods of communication, such as folk-arts, drama, and music.

To support women and mothers in their efforts to improve their health and nutritional status and that of their infants and children, it is important that nutrition education and information be provided to various other individuals who are influential with the family, such as fathers, grandparents, mother-surrogates, community teachers and others who have an impact on the social behaviour and nutritional habits of vulnerable groups, and the education and information should be carried out with their participation.

It is strongly recommended that governments should provide adequate nutrition training in medical and nursing schools, adequate training to primary health care workers, including midwives, particularly in prenatal and perinatal services, school-teachers, rural extension workers and others operating at the community level to enable them to undertake functional health and nutrition education in the community based on the priority needs of the people and with their active participation. The outcome of these endeavours should be increased self-reliance at the community and family level.

It is essential that all personnel who will provide nutrition education be appropriately trained, not only in techniques of communication and education but also in delivering consistent and coherent nutrition and health concepts and practices based on the local sociocultural conditions.

Training

Basic and continuing education and upgrading of information on all aspects of breastfeeding is necessary for health service staff at all levels, including administrators, professional leaders at medical and nursing schools, physicians (especially obstetricians and paediatricians), nurses and midwives at all levels, medical assistants, auxiliaries, social and extension workers, and particularly primary health care workers. Training should place particular emphasis on management of breastfeeding and be related to the economic, cultural and social background of the mother and family. Training should consist of the appropriate knowledge on available culturally acceptable, locally grown foodstuffs which are suitable for use as weaning foods for the young infant and supplementary foods for the pregnant and lactating woman. Health service staff should also be enlightened about the dangers and hazards of advertising infant foods in clinics.

The use of mass media, which in many countries include radio, TV and newspapers, and advertisements for formula and other infant food products in government and professional journals, should be effectively screened by appropriate government ministries to ensure that they do not detract from official nutrition policies designed to protect breastfeeding and the health and nutritional status of mothers and children.

There is not enough information about the present state of education/training in the field of maternal, infant and young child nutrition throughout the world. The Meeting strongly recommends that this be reviewed as soon as possible and followed up every five years in order to evaluate the activities in this field and to use it for updating the programmes. International organizations, especially UNICEF, WHO, FAO, UNESCO and UNIDO, should collaborate in this activity. This also implies collaboration in the preparation of guidelines aimed at identifying problems related to health and nutrition status of mothers and children, particularly regarding conditions of breastfeeding and weaning practices, and on methods of surveillance.
DEVELOPMENT OF SUPPORT FOR IMPROVED HEALTH AND SOCIAL STATUS OF WOMEN IN RELATION TO INFANT AND YOUNG CHILD HEALTH AND FEEDING

Status of women

Participation of women

Women's role and experience in infant feeding are unique and the importance of women gaining greater control of actions affecting this aspect of their lives must be emphasized. It is recommended, therefore, that women's participation in all related actions be significantly increased through:

(i) increased representation of women in all follow-up meetings and actions as recommended by this Meeting, including increased involvement of women in the activities of United Nations agencies, nongovernmental organizations, and other groups, including industry and trade unions;

(ii) the increased recognition and involvement of women's organizations in community, national and international efforts for the promotion of improved infant and young child feeding and related primary health care efforts;

(iii) the increased involvement of women in policy formulation and decision-making at all stages of planning and implementation of related national programmes.

Health and nutritional status of women

Improved infant and young child feeding is closely linked with women's enjoying a high status of health throughout all stages of life, especially in the reproductive cycle. It is recommended that measures be taken to ensure good nutrition and health for all women through:

(i) measures directed towards health care, socially and economically available, particularly according to primary health care, including the provision of balanced and sufficient nutritional intake, especially during pregnancy and lactation, and family planning information and services; special attention should be given to reproductive health and education of adolescent girls with specific action for pregnant adolescents;

(ii) the implementation of activities aiming to reduce women's workload, both in the home and outside the home, including actions to promote the sharing of tasks within the family and including development programmes related in particular to the provision of plentiful and clean water and the use of appropriate technologies.

Measures to support breastfeeding

The woman is pivotal for all action related to breastfeeding. Breastfeeding is best for the health of the young baby, but also for the health of the mother including the physical, emotional, and psychological aspects of her health.

The majority of women living in rural areas and in the urban periphery are not covered by protective or legislative measures; they are either not wage-earners or are workers without adequate security. Very little has been done for these women. It is recommended therefore that there be government action and community development activities, including the help of breastfeeding mothers, to encourage these mothers to breastfeed. Programmes to develop appropriate technologies (especially regarding food production and handling) to reduce these women's workload and to organize community-based day care of children should be emphasized.

Governments should ratify and apply the ILO conventions through national legislation concerning maternity protection which is to be developed (and which extends existing protective measures to increase the period of time of maternity leave) for facilitating breastfeeding, including facilities for breastfeeding, paid nursing breaks, flexible schedules, day care centres and other measures to ensure the physical closeness of mother and child;
these measures should ensure that women's earnings are not substantially reduced or that complementary measures are introduced to provide subsidies; and that any discrimination against nursing mothers in employment should be prohibited. Women's groups and trade unions should pressure governments to ensure the ratification and implementation of appropriate legislation. The ILO, together with WHO and UNICEF and other United Nations agencies, should continue its activities in the application of legislation and protection of breastfeeding mothers.

Specific educational and nutritional programmes within primary health care should be directed towards pregnant women to prepare them psychologically and physically to breastfeed their babies.

Weaning

Women play important roles in the production, preparation and serving of food within the family. The home preparation of appropriate weaning foods will depend on their knowledge, time, human energy and resources.

(i) in all cases where there is access to local food products, it is necessary to teach women and other family members to use these as weaning foods as part of the family diet;

(ii) in cases where women do not have easy access to locally available foods, action should be taken for the organization of community efforts, such as cooperatives, to make such local foods available to women;

(iii) educational and other community development programmes related to health and nutrition should be linked with income-generating activities and policies;

(iv) all food aid programmes in this area should take cognizance of the local food content and habits, and not create a situation of dependency, and should be careful not to compete with breastfeeding and local food production.

Information, education and training

The importance of an adequate basis on which women can have a true and objective choice emphasizes the need for education and information about infant and young child feeding and for the establishment of measures at government levels to protect women against misinformation. Information and education about infant and young child feeding should be directed to men as well as women in order to enable them to assume their supportive responsibilities.

Educational materials to be directed to the general public, to schoolchildren, and to the training of health and other development workers, should project a positive image of women not only in their roles as mothers but also as workers and citizens of the community. This would refer to the images as seen in books and other written material as well as the mass media.

Nongovernmental women's organizations should organize extensive consciousness-raising campaigns for generating policy actions by governments and launching extensive information dissemination campaigns in support of breastfeeding and good weaning habits. At the local level nongovernmental organizations are urged to organize and carry out women-to-women programmes to promote breastfeeding and adequate weaning. In these activities nongovernmental organizations should collaborate with WHO and UNICEF, with the necessary support from national and international agencies.

As in most instances the health care providers to mothers and children are women, special efforts should be directed to strengthening training programmes for these groups of workers to include a comprehensive component of family planning, infant and young child feeding, and other aspects of family health within primary health care.

For all, education of the public - especially of the young generations - should aim at a better acceptance of breastfeeding as the natural and healthiest practice, taking into account cultural specificities and endogenous practices, and using all channels of education as well as the media.
In collaboration with all relevant sectors, particularly health, education, agriculture and industry, governments need to ensure that up-to-date, scientific and empirical information on infant and young child feeding is widely disseminated and applied. A government mechanism must be established to ensure that through continuous screening and monitoring information and publicity relative to maternal, infant and young child feeding are correct and appropriate and that undesirable and inappropriate messages and publicity are eliminated.

A national strategy for communication and education should be formulated to mobilize available resources, this strategy to include training of manpower at all levels to plan, implement, evaluate and conduct research with respect to communication programmes.

Women have the right to correct and full information; even objective information, however, can be misleading and harmful if it is given in inappropriate settings or times. Women's organizations should be involved in national councils or government agencies in the monitoring and enforcement of marketing codes dealing with the regulation of information and publicity. Women in all parts of the world - in developed and developing countries - should express their solidarity in deciding what is best in this unique and important part of their lives.

APPROPRIATE MARKETING AND DISTRIBUTION OF INFANT FORMULA AND WEANING FOODS

The government of each country has the responsibility to promote coherent food and nutrition policies which should give special attention to mothers, infants and children. These policies should emphasize the preservation of breastfeeding and the implementation of appropriate nutritional guidance (calendrier nutritionnel). Governments have a duty to ensure the supply and availability of adequate infant food products to those who need them, in ways that will not discourage breastfeeding. Informed advice should be given at the appropriate time and place to mothers and families about best infant and young child feeding practices.

Breastfeeding is the only natural method of feeding babies and it should be actively protected and encouraged in all countries. Therefore, marketing of breastmilk substitutes and weaning foods should be designed not to discourage breastfeeding.

There should be no sales promotion, including promotional advertising to the public of products to be used as breastmilk substitutes or bottle-fed supplements and feeding bottles. Promotion to health personnel should be restricted to factual and ethical information.

There should be an international code of marketing of infant formula and other products used as breastmilk substitutes. This should be supported by both exporting and importing countries and observed by all manufacturers. WHO and UNICEF are requested to organize the process for its preparation, with the involvement of all concerned parties, in order to reach a conclusion as soon as possible.

Monitoring of marketing practices is recommended. Usually this will be done under government auspices. Advertising councils, industry, consumer and professional groups can make an important contribution.

There should be no marketing or availability of infant formula or weaning foods in a country unless marketing practices are in accord with the national code or legislation if these exist, or, in their absence, with the spirit of this Meeting and the recommendations contained in this report or with any agreed international code.

Facilities of the health care system should never be used for the promotion of artificial feeding. Therefore, advertising or promotional distribution of samples of breastmilk substitutes through health service channels should not be allowed. Artificial feeding should not be openly demonstrated in health facilities.

1 This includes the use of mass media and other forms of advertising directly to the mother or general public, designed to increase sales of breastmilk substitutes, to the detriment of breastfeeding.
No personnel paid by companies producing or selling breastmilk substitutes should be allowed to work in the health care system, even if they are assigned more general responsibilities that do not directly include the promotion of formulas, in order to avoid the risk of conflict of interest.

Production and distribution of foods for infants and young children should be governed by strict legal standards. They should be labelled to indicate proper and safe home preparation. Governments should adopt the recommended international standards covering foods for infants and young children developed by the Codex Alimentarius Committee on Foods for Special Dietary Uses and should support the elaboration of standards by this Committee to ensure nutritional value and safety. Governments that have not yet adopted such codes or regulations are urged to do so.

Products that are not suitable alone as weaning foods, such as sweetened condensed milk, cornstarch, cassava flour and cereal flours, should be required by proper regulations not to be packaged, labelled, advertised or otherwise promoted in ways that suggest they should be used as a complement or substitute for breastmilk. Vigorous educational efforts should be made against their misuse for the purpose by mothers.
1. Introduction

1.1 This report, submitted in compliance with resolution WHA31.56, of 24 May 1978, outlines the action taken in response to the requests contained in operative paragraph 2 of that resolution.

Within the constraints of limited staff and financial resources, these requests have been implemented as far as possible, as indicated below.

2. Activities

2.1 An expert advisory panel on smoking and health has been established; it now comprises 41 members in 26 countries from all WHO regions, and is being expanded.

2.2 A network of collaborating centres located in Canada, Japan, Sweden, the Union of Soviet Socialist Republics, and the United States of America has also been established.

2.3 An expert committee on smoking control was convened in October 1978, and its report, entitled "Controlling the smoking epidemic", has been published.

2.4 In response to operative paragraph 2 (2) of the resolution cited above and in order to provide guidance on crop diversification - particularly to developing countries, some of which are planning to start producing tobacco, and many of which are already experiencing a rapid increase in smoking-related diseases - WHO is taking steps for the establishment of a United Nations interagency advisory group on smoking and health comprising UNICEF, FAO, ILO, UNCTAD, UNDP, UNIDO, and the World Bank. UNESCO is also being consulted for the educational components of anti-smoking campaigns.

2.5 In particular, collaboration has been established with FAO to study the possibility of crop diversification in tobacco-growing areas. The positive reaction of FAO to collaboration with WHO on such a controversial issue as the use of tobacco merits full attention. Before crop diversification can be envisaged, however, it is necessary to evaluate the economic benefits that countries derive from tobacco production, trade and consumption against the costs resulting from smoking-related diseases in the same countries. Quite apart from the ethical and humanitarian factors - which are not taken into consideration when assessing the monetary cost to life and well-being - several scientific reports have shown that the health costs of smoking-related diseases are usually of the same order of magnitude as, and in several countries much higher than, the monetary benefits produced by tobacco.

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1 See resolution WHA33.35.
3 For FAO's views on this topic, see WHO Technical Report Series, No. 636, 1979, p. 84.
2.6 WHO is also co-sponsoring several conferences - the International Conference on Smoking Cessation (New York, 1978), the second European Conference on Smoking and Society (Rotterdam, 1978), the Fourth World Conference on Smoking and Health (Stockholm, 1979), and the forthcoming International Symposium on Passive Smoking (Vienna, 1980).

2.7 In response to operative paragraph 2 (4) of resolution WHA31.56, the Organization drew attention to the health hazards of smoking by selecting as the theme for World Health Day, 1980, "Smoking or health: the choice is yours".

2.8 In 1978 the Regional Office for Europe started the third survey on smoking and health in the European Region.

2.9 The review of legislative action to combat smoking around the world published in 1975 is being updated. A review on smoking and respiratory diseases with reference to the situation in developing countries has been prepared by WHO consultants.

2.10 In addition to close collaboration with nongovernmental organizations such as the International Union against Cancer, the International Society and Federation of Cardiology, the International Union against Tuberculosis, and the International Union for Health Education, which have smoking and health as an important component of their activities, WHO maintains contact with a large number of voluntary associations of non-smokers in about 30 countries.

2.11 These activities are being carried out with the collaboration of several technical programmes both at headquarters and at the regional offices.

2.12 The practical application to public health of the discouragement of smoking through education and public information activities is illustrated by the programmes on comprehensive community control of cardiovascular diseases which are being carried out within the framework of the WHO cardiovascular diseases programme in 23 areas, 11 of which are in developing countries. The emphasis in these programmes is on preventable risk factors such as smoking, hypertension and hyperlipidaemia.

The results from one of these collaborative programmes - in North Karelia, Finland - are particularly revealing. The level of risk factors in the community, including smoking, decreased, and this was accompanied by a significant decrease in the number of cardiovascular cases. This exercise demonstrated the feasibility of carrying out large-scale anti-smoking educational campaigns successfully, and confirmed the beneficial public health effects of the abatement of the smoking habit.

3. Programme evaluation

3.1 As an indication of the interest that WHO activities on smoking and health have aroused among governmental and nongovernmental bodies, health-oriented institutions, individual investigators and the public at large, it is worth mentioning the following. Over 26,000 copies of the reports of the two expert committee meetings held in 1974 and 1978 have been distributed, most of them on sale (this is above average for WHO expert committee reports). About 12,000 information kits for World Health Day on "Smoking or health: the choice is yours" have been distributed on request (without counting the Spanish and Portuguese versions, which are produced by the WHO Regional Office for the Americas); this figure is about twice the number of kits requested for previous World Health Days. The press coverage of WHO's activities on smoking and health has been almost continuous since the first expert committee meeting on this topic, in 1974, in connexion not only with that meeting but also with the second expert committee meeting, the Director-General's speech at the Fourth World Conference on Smoking and Health.

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2 Carlens, E. & Ramström, L. M. Chronic obstructive pulmonary diseases in relation to smoking and occupational hazards - a review with specific reference to the situation in developing countries (in preparation).
on Smoking and Health in 1979, World Health Day in 1980, and numerous national smoking and health campaigns to which WHO's activities provide moral support.

3.2 A group of temporary advisers which met in Geneva in December 1978 emphasized the relevance of the smoking-and-health activities to the primary health care approach in the following terms: smoking control activities are concrete and practical approaches that should be considered as one of the important elements of the primary health care vision, that is, an element involving a degree of individual responsibility, of community involvement and of political will.1

4. Proposed future action

4.1 In general terms, the type and intensity of activities carried out in the near future will depend to a great extent upon the guidance obtained from the Health Assembly. The lines of action started will continue.

4.2 The above-mentioned collaboration with FAO (see paragraph 2.5) would be strengthened, and that with other United Nations agencies should soon become operational.

4.3 The collection and dissemination of information on smoking habits, smoking-related health problems and smoking control activities in Member States, as requested by several Health Assembly resolutions, is expected to be implemented through the establishment in headquarters of an international clearing-house of information on smoking trends.

4.4 Steps have been taken to coordinate internationally standardized analyses of tar and nicotine levels of representative samples of cigarettes sold to developing countries. These are reported to be higher than the levels accepted for cigarettes sold in industrialized countries. WHO collaborating centres are being selected to carry out such analyses.

4.5 Future action is expected to concentrate mainly on collaboration with developing countries.

4.6 In accordance with the recommendations made by the consultation mentioned in paragraph 3.2, WHO would collaborate with selected developing countries in preparing audiovisual material on smoking and health for use in professional training.

4.7 Another recommended activity is that WHO should collaborate by providing guidelines for the design and inclusion of health warnings on cigarette packets that are sold in developing countries.

4.8 Seminars and workshops on smoking and health should be sponsored or co-sponsored by WHO in developing countries.

4.9 The above-mentioned consultation further recommended that preparations should now be started to organize an expert committee on smoking and health problems in developing countries.

4.10 As a follow-up of World Health Day 1980, an intensive worldwide public education campaign concerning the health hazards of smoking could be launched and coordinated under the aegis of WHO. This would require an interdisciplinary approach, covering the behavioural, economic, legislative and other fields, as well as the health aspects. Substantial funds would also be required.

5. Programme constraints

5.1 It must of course be realized that action to control smoking is strongly opposed - both nationally and internationally - by powerful economic, political and social forces. Government ambivalence in this field is notorious, and the Director-General's appeal - on the occasion of the Fourth World Conference on Smoking and Health in 1979 - for political action and determination to deal with the smoking and health problem was most pertinent. Because

of these counter-forces the implementation of Health Assembly resolutions on smoking and health is not an easy task; the task is rendered even more difficult by the limited resources available to WHO for this purpose.

5.2 In January 1970 the Executive Board, in resolution EB45.R9, its first on the subject, requested WHO to affirm its view of the health hazards of smoking. Later resolutions of the Health Assembly and the Executive Board (resolutions WHA23.32, EB47.R42 and WHA24.48) requested the Organization to develop activities aimed at discouraging the habit of smoking. It was not until 1974, however, that it was possible to convene an expert committee on smoking and its effects on health. Following this expert committee meeting WHO activities on smoking and health gained momentum, which was further accelerated in recent years in pursuance of resolutions WHA29.55 and WHA31.56 adopted by the Health Assembly in 1976 and 1978 respectively.

5.3 The recent acceleration of activities has been facilitated by the allocation, since early 1979, of US$ 25 000 per year from voluntary funds for smoking-and-health activities. In view of the Organization's limited regular budget and other priorities, implementation of the Health Assembly and expert committee recommendations for WHO action on the health hazards of smoking will only be possible if substantial extrabudgetary contributions become available.

5.4 Despite the constraints mentioned above, the Expert Committee on Smoking Control considered that these activities are indeed a fit task for WHO to carry out, stating in the Introduction to its report that "in any country where smoking is . . . a common practice, it is a major and certainly removable cause of ill health and premature death . . . The only proper course . . . must be to seek the removal of the hazard . . ." It stated its belief that the reduction of smoking to the status of a private activity of a minority of adults unable to give up the habit "should be seen as an attainable goal within the next two decades at the latest. Nothing less would be compatible with WHO's objective of health for all by the year 2000."2

6. Programme guidance

6.1 Guidance from the Health Assembly is needed on the following:

6.1.1 Are the activities outlined in section 4 appropriate and adequate?

6.1.2 Should the following complex and controversial issues be pursued:

(a) the study on crop diversification in tobacco-growing areas, in collaboration with FAO (paragraph 4.2);

(b) the coordination of a continuing intensive worldwide anti-smoking public education campaign following on World Health Day 1980 (paragraph 4.10)?

6.1.3 In view of the limitations of the regular budget, to what extent and in which order of priority in relation to other programmes should extrabudgetary funds be sought for these activities?

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2 Deputy Chief Delegate from 20 May.
3 Chief Delegate from 9 May.
BANGLADESH

Delegates

Professor M. A. MATIN, Minister of Health and Population Control (Chief Delegate)
Mr. M. SULTAN, Ambassador, Permanent Representative of the People's Republic of Bangladesh to the United Nations Office and Other International Organizations at Geneva (Deputy Chief Delegate)
Mr. A. R. KHAN, Joint Secretary, Health Division, Ministry of Health and Population Control

Alternate

Dr. M. Y. DEWAN, Joint Secretary, Health Division, Ministry of Health and Population Control

Advisers

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
Mr. M. R. BASHIR, Director of Development, International Centre for Diarrhoeal Diseases
Mr. D. U. AHMED, Private Secretary to the Minister of Health and Population Control

BELGIUM

Delegates

Professor S. HALTER, Secretary-General, Ministry of Public Health and Family Welfare (Chief Delegate)
Mr. A. ONKELINX, Ambassador, Permanent Representative of Belgium to the United Nations Office and the Specialized Agencies at Geneva (Deputy Chief Delegate)
Dr. P. DE SCHOUNER, Chef de Cabinet of the Minister of Public Health and Environment

Alternates

Mr. A. BERWAERTS, Inspector and Head of Section, Ministry of Public Health and Family Welfare
Dr. J. BURKE, Chief Physician and Director, General Administration of Cooperation for Development

Mr. J. DE BOCK, Attaché, Permanent Mission of Belgium to the United Nations Office and the Specialized Agencies at Geneva

Advisers

Dr. (Mrs) J. BANDE-KNOPS, Secretary-General, National Child Welfare Organization
Professor F. BARO, Faculty of Medicine, Catholic University of Louvain
Professor L. EYCKMANS, Director, Prince Leopold Institute of Tropical Medicine, Antwerp
Professor W. J. EYLENBOSSCH, Section of Epidemiology and Social Medicine, University of Antwerp
Professor A. HEUSE, President, School of Public Health, Free University of Brussels
Dr. M. KIVITS, Administrator and Secretary, Tropical Medicine Fund
Professor M. LECHAT, School of Public Health, Catholic University of Louvain
Professor A. PRIMS, Faculty of Medicine, Catholic University of Louvain
Dr. Gilberite Marie REGINSTER, Institute of Hygiene and Social Medicine, University of Liège
Professor E. A. SAND, School of Public Health, Free University of Brussels
Professor C. H. THILL, School of Public Health, Free University of Brussels
Professor R. VANBREUSEGHEM, Prince Leopold Institute of Tropical Medicine, Antwerp
Dr. J. VAN ROY, Senior Lecturer, Free University of Brussels
Professor K. VUYLSTEKE, Section of Health and Social Medicine, University of Ghent
Professor (Mrs) E. WOLLAST, Faculty of Medicine, Free University of Brussels

BENIN

Delegates

Mr. P. KPOFPON, Minister of Public Health (Chief Delegate)
Dr. J. E. AKTINOCHE, Director of Studies and Planning, Ministry of Public Health
Professor B.-C. SADELER, Director, Institute of Applied Biomedical Sciences, Faculty of Health Sciences, National University of Benin
### BOLIVIA

**Delegates**
- Dr H. PALAZZI, Minister of Social Welfare and Public Health (Chief Delegate)
- Dr A. CRESPO, Ambassador, Permanent Representative of the Republic of Bolivia to the United Nations Office and the Other International Organizations at Geneva
- Dr J. SALCEDO, Under-Secretary for Public Health, Ministry of Social Welfare and Public Health

**Alternates**
- Mr A. ARGUEDAS, Minister Counsellor, Permanent Mission of the Republic of Bolivia to the United Nations Office and the Other International Organizations at Geneva

### BOTSWANA

**Delegates**
- Mr L. MAKGEKGENENE, Minister of Health (Chief Delegate)
- Dr D. B. SEBINA, Permanent Secretary for Health
- Mrs K. M. MAKHWEDE, Chief Nursing Officer, Ministry of Health

### BRAZIL

**Delegates**
- Mr W. MENDES ARCOVERDE, Minister of Health (Chief Delegate)
- Dr E. P. F. BRAGA, Vice-President, Oswaldo Cruz Foundation; Director, National School of Public Health
- Dr F. L. A. WIENER, Secretary for Planning, National Institute of Medical Assistance and Social Security, Ministry of Social Assistance and Welfare

**Alternates**
- Mrs V. RUMJANEK CHAVES, Officer for International Affairs, Ministry of Health
- Dr G. F. GERHARDT, Director, National Division of Pneumology, Ministry of Health

### BULGARIA

**Delegates**
- Professor R. POPIVANOV, Minister of Public Health (Chief Delegate)
- Professor K. GARGOV, Deputy Minister of Public Health (Deputy Chief Delegate)
- Professor G. NASTEV, Minister Plenipotentiary, Permanent Representation of the People's Republic of Bulgaria to the United Nations Office and the Other International Organizations at Geneva

**Alternates**
- Dr D. KRUSHKOV, Director, Department of International Relations, Ministry of Public Health
- Dr M. MARINOV, Senior Medical Officer, Department of International Health Cooperation, Ministry of Public Health
- Dr K. CHAMOV, Attaché for Research, Institute of Social Hygiene and Public Health Organization, Ministry of Public Health

### BURMA

**Delegates**
- Mr WIN MAUNG, Minister of Health (Chief Delegate)
- Dr SHWE TIN, Director-General, Department of Health, Ministry of Health (Deputy Chief Delegate)
- Dr LUN WAI, Director, Department of Health, Ministry of Health

**Alternates**
- Mr THAUNG HTUN, Second Secretary, Permanent Mission of the Socialist Republic of the Union of Burma to the United Nations Office and Other International Organizations at Geneva
MEMBERSHIP OF THE HEALTH ASSEMBLY

Dr TUN LIN, Assistant Director, Department of Health, Ministry of Health
Mr MYA LWIN, Personal Assistant to the Minister of Health

BURUNDI

Delegates
Dr P. MPITABAKANA, Director-General of Public Health (Chief Delegate)
Dr V. NDAYISABA, Director, Department of Epidemiology and Laboratories, Ministry of Public Health
Mr A. BAZA, Director, Department of Health Logistics, Ministry of Public Health

CANADA

Delegates
Dr L. BLACK, Assistant Deputy Minister, Medical Services Branch, Department of National Health and Welfare (Chief Delegate)
Mr S. MANSBRIDGE, Senior Deputy Minister, Department of Social Services and Community Health, Province of Alberta
Mr W. MORRISSEY, Deputy Minister, Department of Health, Province of New Brunswick

Alternates
Dr Maureen M. LAW, Assistant Deputy Minister, Health Services and Promotion Branch, Department of National Health and Welfare
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Dr W. G. B. CASSELMAN, Senior Adviser, Intergovernmental and International Affairs Branch, Department of National Health and Welfare
Mr R. MCKINNON, Minister Counsellor, Deputy Permanent Representative of Canada to the United Nations Office and the Other International Organizations at Geneva

Advisers
Dr C. W. L. JEANES, Health Sector, Resources Branch, Canadian International Development Agency

Burundi

Mr C. SIROIS, First Secretary, Permanent Mission of Canada to the United Nations Office and the Other International Organizations at Geneva
Mrs L. LEFEBVRE, Bureau of United Nations Affairs, Department of External Affairs

CAPE VERDE

Delegates
Dr J. de D. LISBOA RAMOS, Secretary-General, Ministry of Health and Social Affairs (Chief Delegate)
Dr A. D. FERMINO PINA, Director, Maternal and Child Health and Family Planning Project
Dr C. A. GRAÇA, Health Affairs Delegate, São Vicente

CENTRAL AFRICAN REPUBLIC

Delegates
Dr V. M'BARINDI, Minister of Public Health and Social Affairs (Chief Delegate)
Dr M. D. KPOSSA, Director General of Public Health and Social Affairs
Professor G. PINERD, National WHO Programme Coordinator

CHILE

Delegates
Mr A. MEDINA, Minister of Health (Chief Delegate)
Dr R. SOUMASTRE, Adviser to the Minister of Health
Dr J. M. BORGOÑO, Chief, Department of Public Health, Ministry of Health

Alternate
Mr R. PLAZA, Counsellor, Permanent Mission of Chile to the United Nations Office at Geneva and to the Other International Organizations in Switzerland

Adviser
Mr A. DE LA PARRA, Counsellor, Ministry of Health

1 Chief Delegate from 11 May.

2 Chief Delegate from 14 to 16 May.
Delegates

Mr WANG Wei, Vice-Minister of Public Health (Chief Delegate)
Professor XUE Gongchuo, Director, Bureau of Foreign Affairs, Ministry of Public Health
Dr XU Shouren, Deputy Director, Bureau of Foreign Affairs, Ministry of Public Health

Alternates

Dr CAI Shengga, Deputy Director, Bureau of Medical Policy, Ministry of Public Health
Mr LIN Cheng, Deputy Chief of Division, Department of International Organizations, Treaties and Law, Ministry of Foreign Affairs
Dr WANG Liansheng, Deputy Chief, International Organizations Division, Bureau of Foreign Affairs, Ministry of Public Health

Advisers

Mr LI Zhangqi, Deputy Permanent Representative of the People's Republic of China to the United Nations Office at Geneva and the Other International Organizations in Switzerland
Mr DU Zhongying, Second Secretary, Permanent Mission of the People's Republic of China to the United Nations Office at Geneva and the Other International Organizations in Switzerland
Mr WU Dashou, International Organizations Division, Bureau of Foreign Affairs, Ministry of Public Health
Mrs YAO Ying, Attaché, Permanent Mission of the People's Republic of China to the United Nations Office at Geneva and the Other International Organizations in Switzerland
Mrs XIE Hong, Ministry of Finance
Mr CAO Yonglin, Bureau of Foreign Affairs, Ministry of Public Health
Mrs ZHANG Caiyu, Bureau of Foreign Affairs, Ministry of Public Health

Delegates

Dr A. JARAMILLO, Minister of Health (Chief Delegate)

Dr H. GOMEZ, Chief, Office of International Organizations and Treaties, Ministry of Health
Dr E. GUERRERO, Director, Medical Care Service, Ministry of Health

Alternate

Dr E. ESCOBAR, Director of Environmental Health, Ministry of Health

COMOROS

Delegates

Dr M. MAECHA, Minister of Social Affairs (Chief Delegate)
Mr A. SALIM, Head, Department of Planning and Budget, Ministry of Social Affairs
Dr C. ABBAS, Chief Physician, Medical District of the Governorate of Ngazidja

CONGO

Delegates

Mr P.-D. BOUSSOUKOU-BOUMBA, Minister of Health and Social Affairs (Chief Delegate)
Dr B. S. LOEMBE, Director-General of Health, Ministry of Health and Social Affairs
Dr G. ONDAYE, Director of Coordination and Cooperation, Ministry of Health and Social Affairs

Alternate

Mr E. MBALOULA, Director of Curative Medicine responsible for Hospitals and Basic Health Services, Ministry of Health and Social Affairs

COSTA RICA

Delegates

Dr C. CALVOSA, Minister of Health (Chief Delegate)
Mr M. FREER-JIMENEZ, Ambassador, Permanent Representative of the Republic of Costa Rica to the United Nations Office and the Other International Organizations at Geneva (Deputy Chief Delegate)
Dr L. MARRANGHELLO, Deputy Director-General of Health, Ministry of Health

COLOMBIA
MEMBERSHIP OF THE HEALTH ASSEMBLY

Alternates
Mrs M. QUIROS-GUARDIA, Ambassador,
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Republic of Costa Rica to the United
Nations Office and the Other
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Mrs M. E. ODIO-BENITO, Counsellor,
Permanent Mission of the Republic of
Costa Rica to the United Nations
Office and the Other International
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Adviser
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Director of the Social Security Fund

CUBA

Delegates
Dr S. DEL VALLE, Minister of Public
Health (Chief Delegate)
Dr J. ALDREGUÍA, Vice-Minister of
Public Health (Deputy Chief Delegate)
Mr L. SOLÁ VILA, Ambassador,
Permanent Representative of the
Republic of Cuba to the United
Nations Office and the Other
International Organizations in
Switzerland

Alternates
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Adviser to the Ministry of Public
Health
Professor A. TEJEIRO, Adviser,
Statistical Directorate, Ministry of
Public Health
Dr E. GONZÁLEZ, Vice-Ministry of
Instruction, Ministry of Public
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Mrs A. M. LUETTGEN, Ministry of
External Relations

Advisers
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Department, Directorate of Non-
Aligned Countries, Ministry of
External Relations
Mrs E. PANTOJA, Secretariat of the
Minister of Public Health
Mr J. TAMAYO, Secretariat of the
Minister of Public Health
Mr J. BURGO, Secretariat of the
Minister of Public Health

CYPRUS

Delegates
Mr K. VAKIS, Director-General,
Ministry of Health (Chief Delegate)
Dr A. MARKIDES, Director of Medical
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Mr A. POUYOUROS, Ambassador,
Permanent Representative of Cyprus
to the United Nations Office at
Geneva and Specialized Agencies in
Switzerland

Alternates
Mr M. PISSAS, Counsellor, Deputy
Permanent Representative of Cyprus
to the United Nations Office at
Geneva and Specialized Agencies in
Switzerland
Mr A. PATERAS, Ministry of Health

CZECHOSLOVAKIA

Delegates
Professor J. PROKOPEC, Minister of Health
of the Czech Socialist Republic
(Chief Delegate)
Professor E. MATĚJEŠEK, Minister
of Health of the Slovak Socialist
Republic (Deputy Chief Delegate) 1
Dr Eliška Klivarová, Director,
Foreign Relations Department,
Ministry of Health of the Czech
Socialist Republic

Alternates
Dr K. GECÍK, Director, Secretariat of
the Ministry of Health of the Slovak
Socialist Republic
Miss A. PÁROVÁ, Department for
International Economic Organizations,
Federal Ministry of Foreign Affairs
Mr J. JIRŠEK, Third Secretary,
Permanent Mission of the Czechoslovak
Socialist Republic to the United
Nations Office and the Other
International Organizations at
Geneva

DEMOCRATIC KAMPUCHEA

Delegates
Mr THIOUNN THOEUN, Minister of Health
(Chief Delegate)

1 Chief Delegate from 12 May.
Mr OK Sakun, Ambassador, Permanent Representative of Democratic Kampuchea to the United Nations Office at Geneva and the Other International Organizations in Switzerland (Deputy Chief Delegate)

Mr TE Sun Hao, Counsellor, Deputy Permanent Representative of Democratic Kampuchea to the United Nations Office at Geneva and the Other International Organizations in Switzerland

Alternate
Miss C. Srey, Attaché, Permanent Mission of Democratic Kampuchea to the United Nations Office at Geneva and the Other International Organizations in Switzerland

Democratic People's Republic of Korea

Delegates
Mr Chin Chung Guk, Ambassador, Permanent Observer of the Democratic People's Republic of Korea to the United Nations Office and Permanent Delegate to the Other International Organizations at Geneva (Chief Delegate)

Mr Jang Chang Chon, Second Secretary, Office of the Permanent Observer of the Democratic People's Republic of Korea to the United Nations Office and Permanent Delegation to the Other International Organizations at Geneva

Mr Hwang Yong Hwan, Third Secretary, Office of the Permanent Observer of the Democratic People's Republic of Korea to the United Nations Office and Permanent Delegation to the Other International Organizations at Geneva

Democratic Yemen

Delegates
Dr A. Nashe, Deputy Minister of Public Health (Chief Delegate)

Dr A. Basahai, Director of Preventive Medicine, Ministry of Public Health

Mr A. M. Hasson, Chargé d'Affaires, Permanent Representative of the People's Democratic Republic of Yemen to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

DENMARK

Delegates
Dr S. K. Sørensen, Director-General, National Health Service (Chief Delegate)

Mr G. A. Lustrup, Deputy Permanent Secretary, Ministry of the Interior (Deputy Chief Delegate)

Dr N. Rosdaahl, Deputy Director-General, National Health Service

Alternates
Mr P. Thornit, Head of Section, Ministry of the Interior

Mrs L. E. Olesen, Head, International Coordination Section, National Health Service

Advisers
Dr J. C. Siim, Director (Technical Affairs), Danish National Serum Institute

Mr J. Andersen, Head of Section, Ministry of the Interior

Miss B. Poulsen, Head of Section, Ministry of Foreign Affairs

Dr E. L. Lauridsen, Consultant, Ministry of Foreign Affairs

Mr E. Lassen, Counsellor, Ministry of Foreign Affairs

Mr M. Wagtman, First Secretary, Permanent Mission of Denmark to the United Nations Office and the Other International Organizations at Geneva

Dominican Republic

Delegates
Dr J. Rodríguez Soldevila, Secretary of State for Public Health and Social Assistance (Chief Delegate)

Dr H. L. Hernández, Ambassador, Permanent Representative of the Dominican Republic to the United Nations Office and the Other International Organizations at Geneva

Professor R. de Lancer, Under-Secretary of State for Planning and Development, State Secretariat for Public Health and Social Assistance

1 Chief delegate from 12 to 16 May.

2 Chief delegate from 17 May.
ECUADOR

Delegates
Dr H. GUILLEM MURILLO, Minister of Public Health (Chief Delegate)
Professor M. COELLO, Ambassador of Ecuador to the Federal Republic of Germany
Dr C. HENRIQUEZ, Director-General of Health, Ministry of Public Health

Alternate
Professor Azucena DE QUINNA QUIROZ, Head, Department of International Relations, Ministry of Public Health

Adviser
Mr J. POLIT, General Coordinator, Ministry of Public Health

EGYPT

Delegates
Dr M. GABR, Minister of Health (Chief Delegate)
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. G. KHALLAF, Under-Secretary of State for Development and Research, Ministry of Health

Alternate
Dr I. BASSIOUNI, Director-General, Department of Foreign Health Relations, Ministry of Health

Advisers
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
Mr M. EL-BARADEI, 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 M. S. D. FOUAD, First Under-Secretary of State, Ministry of Health

EL SALVADOR

Delegates
Dr R. GIRÓN FLORES, Minister of Public Health and Social Welfare (Chief Delegate)
Mr N. R. MONGE LÓPEZ, Ambassador, Permanent Representative of the Republic of El Salvador to the United Nations Office and the Other International Organizations at Geneva (Deputy Chief Delegate)
Dr G. BELTRÁN CASTRO, Director-General of Health, Ministry of Public Health and Social Welfare

ETHIOPIA

Delegates
Mr W. SAHLU, Permanent Secretary, Ministry of Health (Chief Delegate)
Mr G. E. TEKA, Head, Planning and Programming Office, Ministry of Health (Deputy Chief Delegate)
Mr Y. TEKESTE, Ex-Manager, Smallpox Eradication Programme, Ministry of Health

Adviser
Mr K. SHENKORU, Second Secretary, Permanent Mission of Ethiopia to the United Nations Office at Geneva
FINLAND

Delegates
Ms S. LUJA-PENTTILA, Minister of Social Affairs and Health (Chief Delegate)
Professor E. KIVALO, Director-General, National Board of Health
Mr M. ONNELA, Director, Department of Health, Ministry of Social Affairs and Health

Alternates
Dr H. HELLBerg, Deputy Director, Public Health Department, National Board of Health
Dr M. PARMALA, Head, International Relations Section, National Board of Health
Mrs L. OLLILA, Secretary for International Affairs, Bureau of International Affairs, Ministry of Social Affairs and Health
Mr I. SALMI, Second Secretary, Political Department, Ministry for Foreign Affairs
Mrs T. RAIvIO, Secretary of Embassy (Social Affairs), Permanent Mission of Finland to the United Nations Office and the Other International Organizations at Geneva

Advisers
Ms H. ROOS, Assistant Director, Ministry of Social Affairs and Health
Ms P. HAMALAINEN, Political Secretary to the Minister of Social Affairs and Health

FRANCE

Delegates
Professor E. J. AUJALEU, Honorary Director-General, National Institute of Health and Medical Research (Chief Delegate)
Professor J.-C. SOURNIA, Director-General of Health, Ministry of Health and Social Security
Dr Jeanne BROyELLA, Inspector-General, Ministry of Health and Social Security

Alternates
Dr G. MARTIN, Médecin général de la Santé, Ministry of Health and Social Security
Mr A. NEMO, Counsellor, Permanent Mission of France to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Dr P. PARADE, Deputy Assistant Director of Health and Social Affairs, Ministry of Cooperation
Professor R. SENAULT, Professor of Hygiene and Social Medicine, Nancy Faculty of Medicine
Mr J. WEBER, Director of Pharmacy and Drugs, Ministry of Health and Social Security

Advisers
Miss J. BALENCIE, Principal Assistant Secretary for Foreign Affairs, Ministry of Foreign Affairs
Mr P. BARBEZIEUX, Attaché, Permanent Mission of France to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Mr L. PICARD, Inspector-General of Social Affairs, Ministry of Health and Social Security; Director, National School of Public Health
Dr J. ROUault, Head, Department of Health Sciences and Technology, National School of Public Health

GABON

Delegates
Mr R. MAMILA, Minister of State, Minister of Public Health and Population (Chief Delegate)
Dr L. ADANDE MENEST, Director-General of Public Health, Ministry of Public Health and Population (Deputy Chief Delegate)
Mr M. MBOUMBA, Director, National Sanitation Service and Urban Hygiene Service

Alternates
Dr R. AKEREY, Director of the National Pharmacy, Inspector of Pharmacies
Dr O. BRAHME-RETO, Director of the Jeanne Ebori Foundation, National Social Security Service
Gambia

Delegates
Mr M. C. JALLOW, Minister of Health, Labour and Social Welfare (Chief Delegate)
Mr S. A. NJAI, Acting Permanent Secretary, Ministry of Health, Labour and Social Welfare
Dr E. M. SAMBA, Director of Medical Services, Ministry of Health, Labour and Social Welfare

Alternates
Dr H. HUYOFF, Senior Lecturer and Senior Physician, Institute of Hygienics, Greifswald University
Mr F. WEGMARSHAUS, Head of Section, Department of International Relations, Ministry of Health
Dr O. HUGLER, First Secretary, Permanent Mission of the German Democratic Republic to the United Nations Office and the Other International Organizations at Geneva
Mrs C. WOLF, Second Secretary, Department of International Economic Organizations, Ministry of Foreign Affairs
Dr H. KRAUSE, Head, Consultative Centre for WHO Questions, Ministry of Health
Mrs K. ADAMCZYK, Scientific Adviser, Consultative Centre for WHO Questions, Ministry of Health

German Democratic Republic

Delegates
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Professor K. SPIES, Deputy Minister of Health
Dr K.-H. LEBENTRAU, Head, Department of International Relations, Ministry of Health

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Mrs C. WOLF, Second Secretary, Department of International Economic Organizations, Ministry of Foreign Affairs
Dr H. KRAUSE, Head, Consultative Centre for WHO Questions, Ministry of Health
Mrs K. ADAMCZYK, Scientific Adviser, Consultative Centre for WHO Questions, Ministry of Health

Germany, Federal Republic of

Delegates
Professor L. VON MANGER-KOENIG, Special Consultant on International Health Affairs to the Federal Minister for Youth, Family Affairs and Health (Chief Delegate)

Alternates
Mr M. P. ANSAH, Minister of Health (Chief Delegate)
Mr J. V. GBEHO, Ambassador, Permanent Representative of the Republic of Ghana to the United Nations Office at Geneva and the Specialized Agencies in Switzerland (Deputy Chief Delegate)

Dr E. BEAUSOLEIL, Director of Medical Services, Ministry of Health

Alternates
Mr I. K. BOATENG, Principal Secretary, Ministry of Health
Dr K. WARD-BREW, Deputy Director of Medical Services, Ministry of Health

Adviser
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GREECE

Delegates
Mr A. CHORAFAS, Ambassador, Permanent Representative of Greece to the United Nations Office at Geneva and the Specialized Agencies in Switzerland (Chief Delegate)
Dr D. SARFATIS, Director-General of Hygiene, Ministry of Social Services (Deputy Chief Delegate)
Mr E. DANELLIS, Counsellor, Permanent Mission of Greece to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Alternates
Dr Méropi VIOLAKI-PARASKEVA, Honorary Director-General of Health, Ministry of Social Services
Professor D. AVRAMIDIS, School of Public Health, Athens
Dr L. LIAROPOULOS, Technical Adviser to the Minister of Social Services
Mr C. IVRAKIS, First Counsellor, Permanent Mission of Greece to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

GUATEMALA

Delegates
Dr R. RECINOS, Minister of Public Health and Social Welfare (Chief Delegate)

GUINEA

Delegates
Professor M. K. BAH, Director-General of Health (Chief Delegate)
Mr A. SOMPARE, Ambassador of Guinea to Switzerland
Dr O. DIALLO, Director of Health Care Services, Ministry of Health

Alternate
Dr M. SYLLA, Deputy Chief Physician, Donka Hospital

GUINEA-BISSAU

Delegates
Mr J. DA COSTA, State Commissioner for Health and Social Affairs (Chief Delegate)
Dr M. RODRIGUES BOAL, Secretary-General, Office of the State Commissioner for Health and Social Affairs (Deputy Chief Delegate)
Dr R. P. DOMINGOS GOMES, Office of the State Commissioner for Health and Social Affairs

Alternate
Mrs M. O. COELHO DE MENDONÇA, Office of the State Commissioner for Health and Social Affairs
GUYANA

Delegates
Mr C. PHILADELPHIA, Permanent Secretary, Ministry of Health, Housing and Labour (Chief Delegate)
Dr T. JONES, Chief Medical Officer, Ministry of Health, Housing and Labour

HAITI

Delegates
Dr J. CADET, Under-Secretary of State for Public Health and Population (Chief Delegate)
Dr G. NICOLAS, Adviser to the Secretary of State for Public Health and Population
Dr Josette BIJOU, Director of the Southern Health Region

HONDURAS

Delegates
Dr L. A. COUSIN, Minister of Public Health (Chief Delegate)
Mr P. GARAY-ALVARADO, Ambassador, Permanent Mission of the Republic of Honduras to the United Nations Office at Geneva and the Other International Organizations in Switzerland
Dr D. VELASQUEZ, Chief, Maternal and Child Health Division, Ministry of Public Health

HUNGARY

Delegates
Dr E. SCHULTHEISZ, Minister of Health (Chief Delegate)
Dr Eva ZSÖGÖN, Secretary of State for Health, Ministry of Health (Deputy Chief Delegate)
Dr L. SANDOR, Head of Department, Ministry of Health

Alternates
Dr L. ÉLIÁS, Deputy Head of Section, Ministry of Health

1 Chief Delegate from 11 May.

Mrs E. OLASZ, First Secretary, Ministry of Foreign Affairs
Mr J. VARGA, Counsellor, Permanent Mission of the Hungarian People’s Republic to the United Nations Office and the Other International Organizations at Geneva
Mr I. SOÓS, Deputy Head of Department, Ministry of Health

Advisers
Dr F. GÁCS, Head of Department, Ministry of Health
Professor I. FORGÁCS, Deputy Head of Department, Ministry of Health
Dr J. BALOG, Deputy Head of Department, Ministry of Health

ICELAND

Delegates
Mr S. GESTSSON, 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 S. JOHNSEN, Medical Officer of Health, Reykjavik
Dr Ó. BJARNASON, Chief Medical Officer of School Health, 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. KROYER, Ambassador, Permanent Representative of Iceland to the United Nations Office and the Other International Organizations at Geneva

INDIA

Delegates
Mr B. SHANKARANAND, Minister for Education, Health and Social Welfare (Chief Delegate)
Mr K. NARAIN, Secretary, Ministry of Health and Family Welfare
(Deputy Chief Delegate)¹
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 N. S. BAKSHI, Deputy Secretary and Special Assistant to the Minister for Education, Health and Social Welfare
Mr A. S. DAS, First Secretary, Permanent Mission of India to the United Nations Office and the Other International Organizations at Geneva

INDONESIA

Delegates
Dr S. SURJANINGRAT, Minister of Health (Chief Delegate)
Professor A. A. LOEDIN, Head, National Institute of Health Research and Development, Ministry of Health (Deputy Chief Delegate)
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Alternate
Dr HAPSARA, Head, Planning Bureau, Ministry of Health

Advisers
Mr S. KUSUMOATMODJO, Minister Counsellor, Permanent Mission of the Republic of Indonesia to the United Nations Office and the Other International Organizations at Geneva
Mr H. REKSODIPUTRO, Third Secretary, Permanent Mission of the Republic of Indonesia to the United Nations Office and the Other International Organizations at Geneva

IRAQ

Delegates
Dr R. I. HUSAIN, Minister of Health (Chief Delegate)
Dr N. AL SHABANDAR, President, State Establishment for Health Education and Training,
Dr A. HASSOUN, Director of International Health Affairs, Ministry of Health

Alternate
Dr S. MORKAS, Deputy Director-General of Preventive Medicine, Ministry of Health

Advisers
Dr S. Y. MICHAEL, President, State Establishment for Drug Industry and Medical Supplies
Mr M. A. AL-MULTAK, Ambassador, Permanent Representative of the Republic of Iraq to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

IRELAND

Delegates
Mr S. GAYNOR, Ambassador, Permanent Representative of Ireland to the United Nations Office and to the Specialized Agencies at Geneva (Chief Delegate)
Mr J. O’SULLIVAN, Assistant Secretary, Department of Health
Dr J. WALSH, Deputy Chief Medical Officer, Department of Health

Alternate
Mr P. McDONAGH, First Secretary, Permanent Mission of Ireland to the United Nations Office and to the Specialized Agencies at Geneva

¹ Chief Delegate from 12 May.
MEMBERSHIP OF THE HEALTH ASSEMBLY

ISRAEL

Delegates
Mr. E. SHOSTAK, Minister of Health
(Chief Delegate)
Professor B. MODAN, Director-General,
Ministry of Health
(Deputy Chief Delegate)
Dr. J. BARRONI, Ambassador, Permanent
Representative of Israel to the
United Nations Office and the
Specialized Agencies at Geneva

Alternates
Professor B. LUNENFELD, Chief, Foreign
Relations, Ministry of Health
Dr. Y. WAYSBOURT, Director,
Hospitalization Services, Ministry
of Health
Professor H. DORON, Chairman,
Sick Fund of the General Federation
of Labour (Histadrut)
Professor M. DAVIES, Director,
Brookdale Institute of Gerontology
Mr. H. S. AYNOR, Ambassador; Director,
African Division, Ministry of
Foreign Affairs
Mrs. R. RAELI, Assistant Director,
Division for International
Organizations, Ministry of Foreign
Affairs
Mr. U. MANOR, First Secretary,
Permanent Mission of Israel to the
United Nations Office and the
Specialized Agencies at Geneva

ITALY

Delegates
Mr. A. ANIASI, Minister of Health
(Chief Delegate)
Mr. V. CORDERO DI MONTEZEMOLO, Ambassador,
Permanent Representative of Italy
at the United Nations Office and
the Other International
Organizations at Geneva
(Deputy Chief Delegate)
Professor R. VANNUGLII, Director,
Office of International Relations,
Ministry of Health

Alternates
Professor L. GIANNICO, Director-
General of Public Health,
Ministry of Health

Mr. M. INCISA DI CAMERANA, Counsellor,
Permanent Mission of Italy to the
United Nations Office and the Other
International Organizations at
Geneva
Professor G. A. CANAPERIA, President,
Italian World Health Centre
Professor F. POCCHIARI, Director
Istituto Superiore di Sanità
Dr. F. L. ODDO, Chief Medical
Inspector General, Ministry of
Health
Mr. E. ROCCO, Office of International
Relations, Ministry of Health
Professor B. PACCAGNELLA, Director,
Institute of Hygiene, University
of Padua
Mr. C. M. OLIVA, Second Secretary,
Permanent Mission of Italy to
the United Nations Office and
the Other International
Organizations at Geneva
Miss M. T. FALCETTA, Attaché,
Permanent Mission of Italy to the
United Nations Office and the
Other International Organizations
at Geneva

Adviser
Mr. U. SESSI, Counsellor,
Treasury Department

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 International
and Regional Relations, Ministry
of Public Health and Population

Advisers
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

1 Chief Delegate from 8 May.
2 Deputy Chief Delegate from 8 May.
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<td><strong>Delegates</strong></td>
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<td>Mr S. MULLINGS, Minister of Health and Social Security (Chief Delegate)</td>
<td>Dr Z. MALHAS, Minister of Health (Chief Delegate)</td>
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<td>Mr D. E. MILLER, Permanent Secretary, Ministry of Health and Social Security</td>
<td>Dr A. YAGHLIAN, Director of Supplies and Stores, Ministry of Health (Deputy Chief Delegate)</td>
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<tr>
<td>Dr Christine MOODY, Acting Chief Medical Officer, Ministry of Health and Social Security</td>
<td>Dr M. SHRAIM, Director of Health Education, Ministry of Health</td>
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<tr>
<td>Mr I. IMAI, Parliamentary Vice-Minister for Health and Welfare (Chief Delegate)</td>
<td>Mr A. K. MAGUGU, Minister for Health (Chief Delegate)</td>
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<td>Mr F. SUZUKI, Ambassador, Permanent Representative of Japan to the United Nations Office and the Other International Organizations at Geneva (Deputy Chief Delegate)</td>
<td>Mr G. R. M'MWIRICHA, Permanent Secretary, Ministry of Health (Deputy Chief Delegate)</td>
</tr>
<tr>
<td>Dr S. YOSHIZAKI, Director-General, Statistics and Information Department, Minister's Secretariat, Ministry of Health and Welfare</td>
<td>Dr W. K. KOINANGE, Director of Medical Services, Ministry of Health</td>
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<tr>
<td>Mrs K. YOKOO, Director, Division of Information Systems Design and Data Processing, Minister's Secretariat, Ministry of Health and Welfare</td>
<td>Dr J. A. ALUOCH, Deputy Director of Medical Services, Ministry of Health</td>
</tr>
<tr>
<td>Mr M. NAKAMURA, Deputy Director, Specialized Agencies Division, United Nations Bureau, Ministry of Foreign Affairs</td>
<td>Professor A. O. WASUNNA, Dean, Faculty of Medicine, University of Nairobi</td>
</tr>
<tr>
<td>Mr T. NAKAMOTO, First Secretary, Permanent Mission of Japan to the United Nations Office and the Other International Organizations at Geneva</td>
<td>Dr A. GIKONYO, Assistant Director of Medical Services, Ministry of Health</td>
</tr>
<tr>
<td>Mr S. TANIGUCHI, First Secretary, Permanent Mission of Japan to the United Nations Office and the Other International Organizations at Geneva</td>
<td>Mrs E. N. NGUGI, Deputy Chief Nursing Officer, Ministry of Health</td>
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<tr>
<td><strong>Adviser</strong></td>
<td><strong>Adviser</strong></td>
</tr>
<tr>
<td>Dr Y. KAWAGUCHI, Deputy Director, International Affairs Division, Minister's Secretariat, Ministry of Health and Welfare</td>
<td>Mrs R. MUSANGI, Senior Assistant Secretary, Ministry of Health</td>
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<tr>
<td>Dr A. R. AL-AWADI, Minister of Public Health (Chief Delegate)</td>
<td>Dr A. R. AL-AWADI, Minister of Public Health (Chief Delegate)</td>
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<tr>
<td>Mr H. AL-DABBAGH, Ambassador, Permanent Representative of the State of Kuwait to the United Nations Office at Geneva and the Specialized Agencies in Switzerland (Deputy Chief Delegate)</td>
<td>Mr H. AL-DABBAGH, Ambassador, Permanent Representative of the State of Kuwait to the United Nations Office at Geneva and the Specialized Agencies in Switzerland (Deputy Chief Delegate)</td>
</tr>
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</table>
MEMBERSHIP OF THE HEALTH ASSEMBLY

Dr A. AL-SAIF, Deputy Chief,
Department of Preventive Medicine,
Ministry of Public Health

Alternates
Dr A. HAMADI, Deputy Director,
Sabah Hospital, Ministry of
Public Health
Mr M. TAWFIK, Legal Adviser,
Ministry of Public Health
Mr A. K. JAAFAR, Director, Office
of the Minister of Public Health
Mr H. AL-JASMI
Mr M. M. AL SHATTI
Mr A. AL JANAIE

LEBANON

Delegates
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Representative of the Republic of
Lebanon to the United Nations
Office at Geneva and the Specialized
Agencies in Switzerland (Chief Delegate)
Mr M. EL-HALLAB, Chief, Sanitary
Engineering Department, Ministry
of Public Health (Deputy Chief
Delegate)
Mr N. ABOU ASSI, Deputy Permanent
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Lebanon to the United Nations
Office at Geneva and the Specialized
Agencies in Switzerland

Alternate
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Mission of the Republic of Lebanon to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

LIBERIA

Delegates
Mr G. J. THOMAS, Acting Chargé
d'affaires, Permanent Mission of the
Republic of Liberia to the United
Nations Office at Geneva (Chief
Delegate)
Mrs E. BOWEN-CARR, Second Secretary,
Permanent Mission of the Republic
of Liberia to the United Nations
Office at Geneva

LIBYAN ARAB JAMAHIRIYA

Delegates
Mr B. M. AHMED BABA, Secretary,
Popular Committee for Health, Ghadames
(Chief Delegate)
Dr S. AZZUZ, Attaché, Permanent
Mission of the Socialist People's
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Specialized Agencies in Switzerland
(Deputy Chief Delegate)
Mr G. EL MANA, Secretary, Popular
Committee for Health, Ghadames

Alternate
Dr R. TAJOURI, Counsellor, Permanent
Mission of the Socialist People's
Libyan Arab Jamahiriya to the United
Nations Office at Geneva and the
Specialized Agencies in Switzerland

LUZEMBOURG

Delegates
Mr E. KRIEPS, Minister of Health
(Chief Delegate)
Dr E. DUHR, Director of Health
(Deputy Chief Delegate)
Mr J. RETTEL, Ambassador, Permanent
Representative of the Grand Duchy of
Luxembourg to the United Nations
Office at Geneva

1 Chief Delegate from 9 May.
THIRTY-THIRD WORLD HEALTH ASSEMBLY

Alternates
Dr J. KOHL, Inspector, Directorate of Health
Mrs M. SCHOLTES-LENNERS, Governmental Adviser, Ministry of Health
Mrs J. ANCEL-LENNERS, Counsellor, Deputy Permanent Representative of the Grand Duchy of Luxembourg to the United Nations Office at Geneva

MADAGASCAR

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Professor E. ANDRIAMAMPIHANTONA, Secretary General, Ministry of Health (Chief Delegate)
Dr E. RIBAIRA, Director of Public Health and Social Hygiene, Ministry of Health
Mr J. RASOLOFONIRINA, Head, International Relations Section, Ministry of Health

MALAWI

Delegates
Mr C. CHAZIYA, Minister of Health (Chief Delegate)
Mr L. B. MALUNGA, Principal Secretary, Ministry of Health
Dr D. CHILEMBA, Chief Medical Officer, Ministry of Health

Alternate
Dr M. CHIRAMBO, Senior Specialist, Ministry of Health

MALAYSIA

Delegates
Mr CHONG Hon Nyan, Minister of Health (Chief Delegate)
Mr J. ALWI, Secretary General, Ministry of Health (Deputy Chief Delegate)
Dr E. MOHAMED, Director, Malaria Eradication Programme, Ministry of Health

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Mr A. M. NAZIR, Second Secretary, Permanent Mission of Malaysia to the United Nations Office and the Other International Organizations at Geneva
Mr K. MAHMOOD, Second Secretary, Permanent Mission of Malaysia to the United Nations Office and the Other International Organizations at Geneva

MALDIVES

Delegates
Mr N. M. HUSSAIN, Minister of Health (Chief Delegate)
Dr A. S. ABDULLAH, Director, National Health Services, Ministry of Health

Mali

Delegates
Dr N. TRACR, 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 A. I. SANGHO, Division of International Economic Cooperation, 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, Department of Health (Deputy Chief Delegate)
Mr A. DEBONO, Private Secretary to the Minister of Health and Environment

Alternate
Mr S. F. BORG, Second Secretary, Deputy Permanent Representative of Malta to the United Nations Office and the Specialized Agencies at Geneva

MAURITANIA

Delegates
Mr A. C. SALL, Secretary General, Ministry of Labour, Health and Social Affairs (Chief Delegate)
MEMBERSHIP OF THE HEALTH ASSEMBLY

Dr M. S. OULD ZEIN, Director of Health Services, Ministry of Labour, Health and Social Affairs
Dr Y. KANE, Chief Physician, Guidimaka Regional Health Centre

MAURITIUS
Delegates
Dr B. GHURBURREN, Minister of Health (Chief Delegate)
Dr J. C. MOHITH, Principal Medical Officer, Ministry of Health (Deputy Chief Delegate)
Dr D. FAREED, Consultant, Ministry of Health

MEXICO
Delegates
Dr J. LAGUNA, Under-Secretary for Planning, Secretariat for Health and Welfare (Chief Delegate)
Dr L. D. MARCIAL, Director-General of International Affairs, Secretariat for Health and Welfare (Deputy Chief Delegate)
Mr C. DE ICALA, Minister Counsellor, Permanent Mission of Mexico to the United Nations Office at Geneva and the Other International Organizations in Switzerland

Alternates
Dr A. FUJIGAKI LECHUGA, Director-General of Epidemiology, Secretariat for Health and Welfare
Miss O. CARRIDO-RUIZ, Third Secretary, Permanent Mission of Mexico to the United Nations Office at Geneva and the Other International Organizations in Switzerland
Mr J. FERNANDEZ MORENO, Chief, Information Service, Medical Subdivision, Social Security Institute

MONACO
Delegates
Dr E. BOERI, Technical Adviser, Permanent Delegate of the Principality of Monaco to the International Health Organizations (Chief Delegate)
Mr D. CASTAUD, Director, Health and Social Affairs

MONGOLIA
Delegates
Mr D. NYAM-OSOR, Minister of Public Health (Chief Delegate)
Dr T. RINGHINORJ, Head, Foreign Relations Division, Ministry of Public Health (Deputy Chief Delegate)
Dr P. DOLOOR, President of the Mongolian Medical Association, Ministry of Public Health

MOROCCO
Delegates
Professor R. RAHILLI, 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 (Deputy Chief Delegate)
Professor A. JOUHARI-OUARAINI, Director of the Office of the Minister of Public Health

Alternates
Mr O. JENNANE, Secretary-General, Ministry of Public Health
Mr M. FERAA, Inspector-General, Ministry of Public Health
Dr M. H. FIZAZI, Chief Physician, Province of El Jadida
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
Mr A. BOUZOURBAA, Press Officer, Ministry of Public Health
Mr A. CHAWKI, Member of the National Council of the Order of Pharmacists

MOZAMBIQUE
Delegates
Dr P. MOCUMBI, Minister of Health (Chief Delegate)
Dr P. I. CARRIDO, Provincial Director of Health, Manica (Deputy Chief Delegate)
Dr Maria Beatriz FERREIRA, Coordinator, International Organizations Section, Ministry of Health
THIRTY-THIRD WORLD HEALTH ASSEMBLY

NEPAL

Delegate
Dr L. POUDAYL, Director-General of Health Services, Ministry of Health

Alternates
Mrs M. da C. VAZ, National Nursing Supervisor
Mr B. C. D. COSSA, Secretary for Public Relations, Ministry of Health
Mr A. BERNARDO, Ministry of Health

NEW ZEALAND

Delegates
Dr R. BARKER, Deputy Director-General of Health, Department of Health (Chief Delegate)
Mrs M. BAZLEY, Director, Division of Nursing, Department of Health
Mr T. O'BRIEN, Permanent Representative of New Zealand to the United Nations Office at Geneva

Alternates
Mr R. RICHARDS, Deputy Permanent Representative of New Zealand to the United Nations Office at Geneva
Mr D. WHITE, Second Secretary, Permanent Mission of New Zealand to the United Nations Office at Geneva

NICARAGUA

Delegates
Dr C. A. AMADOR-KÜHL, Minister of Health (Chief Delegate)
Dr J. MARCOS, Director of International Relations, Ministry of Health
Dr A. SERRANO

Alternate
Mr J. PASQUIER, Permanent Representative of Nicaragua to the United Nations Office and the Other International Organizations at Geneva

NIGER

Delegates
Dr L. LOCO, Secretary-General, Ministry of Public Health and Social Affairs (Chief Delegate)
Dr M. DJERMAKOYE, Director, National Office of Pharmaceutical and Chemical Products (Deputy Chief Delegate)
Dr A. I. CISSE, Director of Hygiene and Mobile Health Care, Ministry of Public Health and Social Affairs

Alternates
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Mr N. EL HADJI, Divisional Chief, Directorate of International Organizations, Ministry of Foreign Affairs and Cooperation

Advisers
Dr H. H. COHEN, Director-General, National Institute of Public Health
Dr R. J. H. KEURSINGA, Ministry of Health and Environmental Protection

1 Chief Delegate from 9 to 16 May.
2 Chief Delegate from 17 May.
<table>
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<tr>
<th>Country</th>
<th>Delegates</th>
<th>Alternates</th>
<th>Advisers</th>
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<tr>
<td></td>
<td>Dr. I. O. N. NSOLO, Director of Medical Services and Training, Federal Ministry of Health (Deputy Chief Delegate)</td>
<td>Dr. A. IKEME, Dean, Faculty of Medicine, University of Jos</td>
<td>Dr. O. A. OWOAJE, Counsellor, Permanent Mission of the Federal Republic of Nigeria to the United Nations Office and the Other International Organizations at Geneva</td>
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<td>Mr. A. ADEFULU, Commissioner of Health, Ministry of Health of Ogun State</td>
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</tbody>
</table>
| | | | | **NORWAY**
| **Delegates** | Dr. T. MORK, Director-General of Health Services (Chief Delegate) | Mr. J. CAPPELEN, Ambassador, Permanent Representative of Norway to the United Nations Office and the Other International Organizations at Geneva | Mr. R. DAHL, Head of Division, Norwegian Agency for International Development |
| | Dr. J. WIIK, County Medical Officer | Dr. C. LERCHE, Director, National Institute of Public Health | Mr. B. UTHEIM, Counsellor, Permanent Mission of Norway to the United Nations Office and the Other International Organizations at Geneva |
| | Dr. O. T. CHRISTIANSEN, Deputy Director, Ministry of Social Affairs | Dr. J. GRUND, Director of Planning, Directorate of Health | Mr. R. DAHL, Head of Division, Norwegian Agency for International Development |
| **Alternates** | Mr. J. CAPPELEN, Ambassador, Permanent Representative of Norway to the United Nations Office and the Other International Organizations at Geneva | Mr. B. UTHEIM, Counsellor, Permanent Mission of Norway to the United Nations Office and the Other International Organizations at Geneva | Mr. R. DAHL, Head of Division, Norwegian Agency for International Development |
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| | Mr. J. CAPPELEN, Ambassador, Permanent Representative of Norway to the United Nations Office and the Other International Organizations at Geneva | Mr. B. UTHEIM, Counsellor, Permanent Mission of Norway to the United Nations Office and the Other International Organizations at Geneva | Mr. R. DAHL, Head of Division, Norwegian Agency for International Development |
| | Mr. J. CAPPELEN, Ambassador, Permanent Representative of Norway to the United Nations Office and the Other International Organizations at Geneva | Mr. B. UTHEIM, Counsellor, Permanent Mission of Norway to the United Nations Office and the Other International Organizations at Geneva | Mr. R. DAHL, Head of Division, Norwegian Agency for International Development |
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| | Mr. J. CAPPELEN, Ambassador, Permanent Representative of Norway to the United Nations Office and the Other International Organizations at Geneva | Mr. B. UTHEIM, Counsellor, Permanent Mission of Norway to the United Nations Office and the Other International Organizations at Geneva | Mr. R. DAHL, Head of Division, Norwegian Agency for International Development |
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RWANDA

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SAMOA

Delegates
Mr A. FAUMUINA, Minister of Health
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Dr K. W. RIDINGS, Director-General
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1 From 5 to 16 May.
Delegates
Miss M.-A. BONELLI, Head, Secretariat of State for Foreign Affairs (Chief Delegate)
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Delegate
Dr A. S. MARQUES DE LIMA, Director of Hospitals

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SIERRA LEONE

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1 Admitted to membership by the Thirty-third World Health Assembly on 6 May 1980 (resolution WHA33.1).
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- Mr. E. YBÁNEZ, Under-Secretary for Health and Social Security, Ministry of Health and Social Security

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### SUDAN

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Dr Y. OSMAN, Director-General of Occupational Health, Ministry of Health
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¹ Chief Delegate from 12 May.
² Chief Delegate from 9 May.

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UNITED REPUBLIC OF CAMEROON

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VENEZUELA

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Dr J. RODRÍGUEZ DÍAZ, Chief, International Public Health Office, Ministry of Health and Social Assistance
Dr H. GARCÍA BARRIOS, Director of Public Health, Ministry of Health and Social Assistance

Alternate

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Dr H. CHÁVEZ, Legal Adviser, Ministry of Health and Social Assistance

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Dr M. HAGAR, Director of Preventive Medicine, Ministry of Health

YUGOSLAVIA

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Dr D. KOMADINA, Director, Federal Bureau for Social Welfare

Advisers

Dr B. SKUPNJAK, Director, Institute for Health Organization Economics, Zagreb
Mr D. BOBAREVIć, Senior Adviser and Head of the Group for International Cooperation in the Field of Health, Federal Committee for Labour, Health and Social Welfare

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Alternates
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Mrs H. K. MATANDA, Chief Nursing Officer, Ministry of Health

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REPRESENTATIVE OF AN ASSOCIATE MEMBER

NAMIBIA

Dr Libertine I. AMATHILA, Deputy Secretary for Health and Social Welfare

1 Admitted to membership by the Thirty-third World Health Assembly on 6 May 1980 (resolution WHA33.2).
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**OBservers for non-member states**

**Holy See**

Monsignor J. GERAUD  
Dr F. BOLECH  
Dr Marie-Thérèse GRABER-DUVERNAY

**Observers**

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Professor J. LANGUILLON, Technical Adviser, International Committee of the Sovereign Order of Malta for Aid to Leprosy Victims

**Observers invited in accordance with resolution WHA27.37**

**African National Congress (South Africa)**

Dr P. MFELANG, Medical Officer  
Dr G. V. REDDY, Psychiatrist

**Palestine Liberation Organization**

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Mr S. ARMALI  
Dr A. BASHIR  
Mr D. BARAKAT, Permanent Observer of the Palestine Liberation Organization to the United Nations Office at Geneva  
Mrs N. AWAD, Legal Counsellor, Palestine Red Crescent Society  
PAN Africanist Congress of Azania (South Africa)  
Mr C. M. MSOMI, Department of Publicity and Information

**Members of the special committee of experts to study the health conditions of the inhabitants of the occupied territories in the Middle East**

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Dr M. H. SOEBODRO  
Dr Madiou TOURÉ
United Nations

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Mr G. BRAND, Chief, Research, Studies and Prevention of Discrimination Section, Division of Human Rights
Mrs L. WALDHHEIM-NATURAL, Chief, Geneva Unit, Centre for Disarmament
Mr E. ANDERSON, Director, Office of the Disaster Relief Coordinator
Mr R. SOURIA, Coordination Officer

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Miss Z. BEKKER, External Relations Officer, UNDP European Office

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Dr O. U. ALOZIE, Senior Programme Officer, Environmental Management Division

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Dr K. BALASUBRAMANIAM, Economic Affairs Officer, Technology Division

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International Narcotics Control Board

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United Nations Fund for Drug Abuse Control

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Mr E. LOEBUS, Programme Officer, UNFDAC/UNDP
Mr H. EMBLAD, Assistant Executive Director

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Mr P. SCHATZER, Liaison Officer, Geneva Office

Office of the United Nations High Commissioner for Refugees

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Miss C. HAMLISCH, Inter-Agency Coordination Officer

International Labour Organization

Mr J. DE GIVRY, Chief, Working Conditions and Environment Department
Dr M. STILON DE PIRO, Occupational Safety and Health Branch
Mr A. LAHLOU, Official Relations Branch
Mrs A. SETH-MANI, Official Relations Branch
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| Food and Agriculture Organization of the United Nations | Mr S. AKBIL, FAO Representative to United Nations Organizations in Geneva  
Miss B. M. JENNINGS |
| International Bank for Reconstruction and Development (World Bank) | Dr K. KANAGARATNAM, Senior Adviser, Population, Health and Nutrition Department |
| Inter-Governmental Maritime Consultative Organization | Mr F. D. MASSON, Liaison Officer |
| International Atomic Energy Agency | Mrs M. S. OPELZ, Head, IAEA Liaison Office in Geneva  
Miss A. WEBSTER, IAEA Liaison Office in Geneva |

### REPRESENTATIVES OF OTHER INTERGOVERNMENTAL ORGANIZATIONS

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Dr ERISKAT, Chief of Section, General Directorate for Employment and Social Affairs |
| Commonwealth Secretariat | Professor Sir Kenneth STUART, Medical Adviser  
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Dr P. MOCUMBI (Mozambique)

Secretary:  
Dr H. MAHLER, Director-General

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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: Angola, Argentina, Benin, Botswana, Burundi, Chile, China, Czechoslovakia, France, Iraq, Saudi Arabia, Sri Lanka, Sudan, Union of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, United States of America.

Chairman: Dr A. R. AL-AWADI (Kuwait), President of the Health Assembly
Secretary: Dr H. MAHLER, Director-General

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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.

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Vice-Chairmen: Dr E. G. BEAUSOLEIL (Ghana), and Dr N. W. TAVIL (Papua New Guinea)
Rapporteur: Mr N. N. VOVRA (India)
Secretary: Mrs I. BRÜGEMANN (Development of Health Programme Evaluation)

Committee B

Chairman: Dr E. M. SAMBA (Gambia)
Vice-Chairmen: Mr D. J. DE GEER (Netherlands) and Mr B. C. PERERA (Sri Lanka)
Rapporteur: Mrs T. RAIVIO (Finland)
Secretary: Dr O. W. CHRISTENSEN (Coordination with Other Organizations)
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