WHA34/1981/REC/1

WORLD HEALTH ORGANIZATION

THIRTY-FOURTH WORLD HEALTH ASSEMBLY

GENEVA, 4-22 MAY 1981

RESOLUTIONS AND DECISIONS
ANNEXES

GENEVA
1981

ABBREVIATIONS

The following abbreviations are used in WHO documentation:

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

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PREFACE

The Thirty-fourth World Health Assembly was held at the Palais des Nations, Geneva, from 4 to 22 May 1981, in accordance with the decision of the Executive Board at its sixty-sixth session. Its proceedings are published in three volumes, containing, in addition to other relevant material:

Resolutions and decisions,[1] and list of participants - document WHA34/1981/REC/1

Verbatim records of plenary meetings, and committee reports - document WHA34/1981/REC/2

Summary records of committees - document WHA34/1981/REC/3

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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 1980. A list of the dates of sessions, indicating resolution symbols and the volumes in which the resolutions and decisions were first published, is given in Volume II of the Handbook (page XIII).

RESOLUTIONS

WHA34.1 Interim financial report on the accounts of WHO for 1980, and report of the External Auditor

The Thirty-fourth World Health Assembly,

Having examined the interim financial report[1] and the report of the External Auditor for the year 1980;[2]

Having noted the report of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-fourth World Health Assembly;[3]

ACCEPTS the Director-General's interim financial report and the report of the External Auditor for the year 1980.

Hbk Res., Vol. II (4th ed.), 6.1.10.3

(Twelfth plenary meeting, 15 May 1981 - Committee B, first report)

WHA34.2 Status of collection of assessed contributions and status of advances to the Working Capital Fund

The Thirty-fourth World Health Assembly

1. NOTES the status, as at 12 May 1981, of the collection of assessed contributions and of advances to the Working Capital Fund, as reported by the Director-General;[4]

2. CALLS THE ATTENTION of Members to the importance of paying their annual instalments as early as possible in the year in which they are due, in order that the approved programme can be carried out as planned;

3. URGES Members in arrears to make special efforts to liquidate their arrears during 1981;

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 (4th ed.), 6.1.2.4

(Twelfth plenary meeting, 15 May 1981 - Committee B, first report)

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[1] Document A34/9.

[2] Documents A34/25 and Add.1.

[3] Document A34/30.

[4] Document A34/10.

WHA34.3 Members in arrears in the payment of their contributions to an extent which may invoke Article 7 of the Constitution

The Thirty-fourth World Health Assembly,

Having considered the report of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-fourth World Health Assembly on Members in arrears to an extent which may invoke the provisions of Article 7 of the Constitution;[1]

Having noted that the Central African Republic, Chad, Grenada and Mali 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;

1. DECIDES not to suspend the voting privileges of the Central African Republic, Chad, Grenada and Mali;

2. URGES these Members to intensify efforts in order to regularize their position, either by the payment of contributions or by proposing special arrangements for payment at the earliest possible date;

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

Hbk Res., Vol. II (4th ed.), 6.1.2.4

(Twelfth plenary meeting, 15 May 1981 - Committee B, first report)

WHA34.4 Reimbursement of travel costs of representatives to regional committees

The Thirty-fourth World Health Assembly,

Having noted that in recent years certain Member States have either been unable to send representatives to sessions of regional committees because of financial constraints, or have sent representatives and incurred financial hardship in doing so;

Having noted further the views and recommendations of regional committees and the Executive Board on this matter;

DECIDES that the actual cost of travel, excluding per diem, of one representative to sessions of regional committees may be financed by the Organization upon request of those Members and Associate Members whose contributions to the WHO regular budget are at the minimum rate in the scale of assessments, the maximum reimbursement being restricted to the equivalent of one economy/tourist return air ticket from the capital city of the Member to the place of the session.

Hbk Res., Vol. II (4th ed.), 6.1.12

(Twelfth plenary meeting, 15 May 1981 - Committee B, first report)

[1] Document A34/31.

WHA34.5 Report on casual income and budgetary rate of exchange between the United States dollar and the Swiss franc for 1982-1983

The Thirty-fourth World Health Assembly,

Having considered the report of the Director-General on casual income and budgetary rate of exchange between the US dollar and the Swiss franc for 1982-1983;[1]

1. AUTHORIZES the Director-General, notwithstanding the provisions of Financial Regulation 4.1 and the terms of the Appropriation Resolution for the financial period 1982-1983, to charge against available casual income the net additional costs to the Organization under the regular programme budget resulting from differences between the WHO budgetary rate of exchange and the United Nations/WHO accounting rates of exchange with respect to the US dollar/Swiss franc relationship prevailing during this financial period, provided that such charges against casual income shall not exceed US$ 20 000 000 in 1982-1983;

2. REQUESTS the Director-General, notwithstanding the provisions of Financial Regulation 4.1 and the terms of the Appropriation Resolution for the financial period 1982-1983, to transfer to casual income the net savings under the regular programme budget resulting from differences between the WHO budgetary rate of exchange and the United Nations/WHO accounting rates of exchange with respect to the US dollar/Swiss franc relationship prevailing during this financial period, provided that, having regard to inflationary trends and other factors which may affect the implementation of the regular programme budget, such transfers to casual income need not exceed US$ 20 000 000 in 1982-1983;

3. FURTHER REQUESTS the Director-General to report such charges or transfers in the financial report for the financial period 1982-1983;

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

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

Hbk Res., Vol. II (4th ed.), 2.3.10

(Twelfth plenary meeting, 15 May 1981 - Committee B, first report)

WHA34.6 Assessment of Saint Lucia

The Thirty-fourth World Health Assembly,

Noting that Saint Lucia, 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 November 1980;

Noting that the United Nations General Assembly, in resolution 35/11, established the assessment of Saint Lucia 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;

[1] See Annex 1.

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 Saint Lucia shall be assessed at the rate of 0.01% for 1980-1981 and future financial periods;

(2) that that portion of the 1980-1981 assessment which relates to the year 1980 shall be reduced to one-ninth of 0.01%.

Hbk Res., Vol. II (4th ed.), 6.1.2.2

(Twelfth plenary meeting, 15 May 1981 - Committee B, first report)

WHA34.7 Scale of assessments for the financial period 1982-1983

The Thirty-fourth World Health Assembly

1. DECIDES that the scale of assessments for 1982-1983 shall, subject to the provisions of paragraph 2 below, be as follows:

Member	Assessment (percentage)
Afghanistan	0.01
Albania	0.01
Algeria	0.12
Angola	0.01
Argentina	0.77
Australia	1.80
Austria	0.70
Bahamas	0.01
Bahrain	0.01
Bangladesh	0.04
Barbados	0.01
Belgium	1.20
Benin	0.01
Bolivia	0.01
Botswana	0.01
Brazil	1.25
Bulgaria	0.16
Burma	0.01
Burundi	0.01
Byelorussian Soviet Socialist Republic	0.38
Canada	3.22
Cape Verde	0.01
Central African Republic	0.01
Chad	0.01
Chile	0.07
China	1.59
Colombia	0.11
Comoros	0.01
Congo	0.01

Member	Assessment (percentage)
Costa Rica	0.02
Cuba	0.11
Cyprus	0.01
Czechoslovakia	0.81
Democratic Kampuchea	0.01
Democratic People's Republic of Korea	0.05
Democratic Yemen	0.01
Denmark	0.73
Djibouti	0.01
Dominican Republic	0.03
Ecuador	0.02
Egypt	0.07
El Salvador	0.01
Equatorial Guinea	0.01
Ethiopia	0.01
Fiji	0.01
Finland	0.47
France	6.15
Gabon	0.02
Gambia	0.01
German Democratic Republic	1.37
Germany, Federal Republic of	8.17
Ghana	0.03
Greece	0.34
Grenada	0.01
Guatemala	0.02
Guinea	0.01
Guinea-Bissau	0.01
Guyana	0.01
Haiti	0.01
Honduras	0.01
Hungary	0.32
Iceland	0.03
India	0.59
Indonesia	0.16
Iran	0.64
Iraq	0.12
Ireland	0.16
Israel	0.24
Italy	3.39
Ivory Coast	0.03
Jamaica	0.02
Japan	9.42
Jordan	0.01
Kenya	0.01
Kuwait	0.20
Lao People's Democratic Republic	0.01
Lebanon	0.03
Lesotho	0.01
Liberia	0.01
Libyan Arab Jamahiriya	0.22
Luxembourg	0.05
Madagascar	0.01
Malawi	0.01
Malaysia	0.09
Maldives	0.01
Mali	0.01
Malta	0.01

Member	Assessment (percentage)
Mauritania	0.01
Mauritius	0.01
Mexico	0.75
Monaco	0.01
Mongolia	0.01
Morocco	0.05
Mozambique	0.01
Namibia	0.01
Nepal	0.01
Netherlands	1.60
New Zealand	0.26
Nicaragua	0.01
Niger	0.01
Nigeria	0.16
Norway	0.49
Oman	0.01
Pakistan	0.07
Panama	0.02
Papua New Guinea	0.01
Paraguay	0.01
Peru	0.06
Philippines	0.10
Poland	1.22
Portugal	0.19
Qatar	0.03
Republic of Korea	0.15
Romania	0.20
Rwanda	0.01
Saint Lucia	0.01
Samoa	0.01
San Marino	0.01
Sao Tome and Principe	0.01
Saudi Arabia	0.57
Senegal	0.01
Seychelles	0.01
Sierra Leone	0.01
Singapore	0.08
Somalia	0.01
South Africa	0.41
Spain	1.67
Sri Lanka	0.02
Sudan	0.01
Suriname	0.01
Swaziland	0.01
Sweden	1.29
Switzerland	1.03
Syrian Arab Republic	0.03
Thailand	0.10
Togo	0.01
Tonga	0.01
Trinidad and Tobago	0.03
Tunisia	0.03
Turkey	0.29
Uganda	0.01
Ukrainian Soviet Socialist Republic	1.44
Union of Soviet Socialist Republics	10.91
United Arab Emirates	0.10
United Kingdom of Great Britain and Northern Ireland	4.38

Member	Assessment (percentage)
United Republic of Cameroon	0.01
United Republic of Tanzania	0.01
United States of America	25.00
Upper Volta	0.01
Uruguay	0.04
Venezuela	0.49
Viet Nam	0.03
Yemen	0.01
Yugoslavia	0.41
Zaire	0.02
Zambia	0.02
Zimbabwe	0.01

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

Hbk Res., Vol. II (4th ed.), 6.1.2.1

(Twelfth plenary meeting, 15 May 1981 - Committee B, first report)

WHA34.8 Salaries and allowances for ungraded posts and for the Director-General

The Thirty-fourth World Health Assembly,

Noting the recommendations of the Executive Board with regard to remuneration of staff in the ungraded posts and of the Director-General;

1. CONCURS in the recommendations of the Board; and, in consequence,

2. ESTABLISHES the salary for the posts of Assistant Directors-General and Regional Directors at US$ 85 864 per annum before staff assessment, resulting in a modified net salary of US$ 50 525 (dependency rate) or US$ 46 042 (single rate);

3. ESTABLISHES the salary for the post of Deputy Director-General at US$ 98 132 per annum before staff assessment, resulting in a modified net salary of US$ 55 637 (dependency rate) or US$ 50 497 (single rate);

4. ESTABLISHES the salary for the Director-General at US$ 125 400 per annum before staff assessment, resulting in a modified net salary of US$ 66 817 (dependency rate) or US$ 60 177 (single rate);

5. NOTES that, concurrent with the changes of the salary schedules for these officials, appropriate reduction will be made of the post adjustment applicable to these posts;

6. DECIDES that these adjustments in remuneration shall be effective from 1 January 1981.

Hbk Res., Vol. II (4th ed.), 6.2.4.3

(Thirteenth plenary meeting, 18 May 1981 - Committee B, second report)

WHA34.9 Appointment of External Auditor

The Thirty-fourth World Health Assembly

1. RESOLVES that the holder of the office of Comptroller and Auditor General of the United Kingdom of Great Britain and Northern Ireland be appointed External Auditor of the accounts of the World Health Organization for the financial period 1982-1983 and that he conduct his audits in accordance with the principles incorporated in Article XII of the Financial Regulations, with the provision that, should the necessity arise, he may designate a representative to act in his absence;

2. EXPRESSES its appreciation to Sir Douglas Henley for the work he has performed for the Organization as External Auditor.

Hbk Res., Vol. II (4th ed.), 6.1.10.1

(Thirteenth plenary meeting, 18 May 1981 - Committee B, second report)

WHA34.10 Headquarters accommodation requirements

The Thirty-fourth World Health Assembly,

Having considered resolution EB67.R18 and the Director-General's report on headquarters accommodation requirements;[1]

1. AUTHORIZES the Director-General to proceed with the construction of additional facilities at headquarters at a cost now estimated at Sw.fr. 9 800 000;

2. APPROVES the financial arrangements proposed by the Director-General in respect of the building extension, including inter alia:

(1) deferral of reimbursement of the Swiss loan from the period 1981-1987 to the period 1988-1994, in agreement with the Swiss Government, such deferral in respect of funds appropriated or to be appropriated for the purpose of reimbursement to take place notwithstanding the provisions of Financial Regulation 4.1;

(2) the charging of rent to extrabudgetary funds as from 1 January 1982 in respect of space occupied by staff and facilities financed from such extrabudgetary funds;

(3) temporary internal borrowing from the Working Capital Fund or other available cash resources of the Organization, excluding Trust Funds, for the purpose of meeting the cost of construction, such internal borrowing to be repaid as and when income becomes available;

3. REQUESTS the Director-General to report at appropriate intervals to the Executive Board and the Health Assembly on progress in constructing the extension.

Hbk Res., Vol. II (4th ed.), 6.3.2

(Thirteenth plenary meeting, 18 May 1981 - Committee B, second report)

[1] Document EB67/1981/REC/1, Annex 7.

WHA34.11 Transfer of the Regional Office for the Eastern Mediterranean

The Thirty-fourth World Health Assembly,

Recalling resolution WHA33.16 deciding to submit to the International Court of Justice for its Advisory Opinion certain questions before taking any decision on a transfer of the Regional Office;

Having considered the Advisory Opinion on these questions given by the International Court of Justice;[1]

Recalling further the study of the working group of the Executive Board concerning aspects of the question of a transfer of the Regional Office for the Eastern Mediterranean;

Recognizing the wishes of the majority of Member countries of the Eastern Mediterranean Region to transfer the Regional Office from Alexandria;

1. THANKS the International Court of Justice for its Advisory Opinion on the questions submitted to the Court by the World Health Organization;

2. ACCEPTS the Advisory Opinion of the International Court of Justice of 20 December 1980 and recommends to all parties concerned to be guided by it;

3. REQUESTS the Director-General:

(1) to initiate action as contained in paragraph 51 of the Advisory Opinion and report the results to the sixty-ninth session of the Executive Board in January 1982 for consideration and recommendation to the Thirty-fifth World Health Assembly in May 1982;

(2) to continue to take whatever action he considers necessary to ensure the smooth operations of the technical, administrative and managerial programmes of the Regional Office for the Eastern Mediterranean during the period of consultation;

4. REQUESTS the Government of Egypt to hold consultations with the Director-General as mentioned above.

Hbk Res., Vol. II (4th ed.), 4.2.5 (Thirteenth plenary meeting, 18 May 1981 - Committee B, second report)

WHA34.12 Real Estate Fund

The Thirty-fourth World Health Assembly,

Having considered resolution EB67.R20 and the report of the Director-General on the status of projects financed from the Real Estate Fund, the estimated requirements of the Fund for the period 1 June 1981 to 31 May 1982, and also information on the long-term requirements of the regional offices;[2]

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

1. NOTES that at present there are no identifiable long-term requirements for financing the construction of accommodation at any of WHO's regional offices from the Real Estate Fund;

[1] See Annex 2.

[2] Document EB67/1981/REC/1, Annex 9.

2. REQUESTS the Director-General to keep the long-term accommodation requirements of the Organization at headquarters and in the regional offices under review and to report on the subject to the Executive Board whenever warranted;

3. AUTHORIZES the financing from the Real Estate Fund of the projects summarized in section 11 of the Director-General's report and of the cost of construction of a small office building and staff housing in Malabo, Equatorial Guinea, at the following estimated costs:

	US $
- Conversion of staff housing at the Regional Office for Africa	322 000
- Repairs and alterations to the building and grounds of the Regional Office for Africa	125 000
- Contribution towards the construction of a building for the joint WHO/PAHO Publications and Documentation Service and the office of the PAHO representative for Area II in Mexico	250 000
- Construction of an extension to the Regional Office for South-East Asia, including a new air-conditioning plant and an electric substation	675 000
- Preliminary architectural study for an extension to the Regional Office for Europe	66 000
- Lift and toilet facilities for disabled persons in the Regional Office for Europe	51 000
- Repairs and alterations to the Regional Office for the Western Pacific	275 000
- Construction of a small office building and staff housing in Malabo, Equatorial Guinea	480 000

4. REQUESTS the Director-General to minimize the financial impact on the Organization of the authorized construction in Malabo, Equatorial Guinea, by coordinating these office and staff housing needs with those of other multilateral agencies providing or planning to provide assistance to Equatorial Guinea, in the interest of economy to all participating agencies, and to report to the Executive Board on the outcome of these efforts;

5. APPROPRIATES to the Real Estate Fund, from casual income, the sum of US$ 2 044 000.

Hbk Res., Vol. II (4th ed.), 6.1.7

(Fourteenth plenary meeting, 20 May 1981 - Committee B, third report)

WHA34.13 Amendment of the International Health Regulations (1969)

The Thirty-fourth World Health Assembly,

Recalling resolution WHA33.3, which declares solemnly that the world and all its peoples have won freedom from smallpox;

Considering that, in consequence, the time has come for smallpox no longer to be included among the diseases subject to the International Health Regulations (1969), as amended by the Additional Regulations adopted on 23 May 1973;[1]

[1] International Health Regulations (1969), second annotated edition, Geneva, World Health Organization, 1974.

Recalling the amendments relating to Articles 18, 19, paragraph 2(e), and 47, paragraph 2, kept in abeyance in accordance with resolution WHA27.45;[1]

Having examined the report forwarded to it by the Executive Board at its sixty-seventh session;[2]

Having regard to Articles 2(k), 21(a) and 22 of the Constitution;

1. DECIDES that smallpox shall no longer be included among the diseases subject to the International Health Regulations (1969), as amended by the Additional Regulations adopted on 23 May 1973;

2. INCLUDES smallpox among the diseases under international surveillance in accordance with resolution WHA22.47, the provisions of which apply in view of the global eradication of smallpox;

3. ADOPTS, this twentieth day of May 1981, the following Additional Regulations:

ARTICLE I

The International Health Regulations (1969) are amended as follows:

PART I - DEFINITIONS

Article 1

"diseases subject to the Regulations". Delete the words "smallpox, including variola minor (alastrim)", so that the definition reads as follows:

"'diseases subject to the Regulations' (quarantinable diseases) means cholera, including cholera due to the eltor vibrio, plague, and yellow fever;"

PART II - NOTIFICATIONS AND EPIDEMIOLOGICAL INFORMATION

Article 7

Paragraph 2, subparagraph (a). Delete the word "smallpox", so that the subparagraph reads as follows:

"(a) in the case of plague or cholera, a period of time equal to at least twice the incubation period of the disease, as hereinafter provided, has elapsed since the last case identified has died, recovered or been isolated, and there is no epidemiological evidence of spread of that disease to any contiguous area;"

PART III - HEALTH ORGANIZATION

Article 18

Delete, and renumber Article 19 and succeeding articles throughout the Regulations.

Article 19

Paragraph 2, subparagraph (e). Delete the words "for vaccination against smallpox, and facilities within the airport" and "cholera and", so that the subparagraph reads as follows:

"(e) facilities within the airport or available to it for vaccination against yellow fever."

PART IV - HEALTH MEASURES AND PROCEDURE

Chapter V - Measures concerning the International Transport of Cargo, Goods, Baggage, and Mail

[1] WHO Official Records, No. 217, 1974, pp. 21, 71 and 81.

[2] Document EB67/1981/REC/1, Annex 4.

Article 47

Paragraph 2. Delete the words "Apart from the measures provided for in Article 64," so that the paragraph reads as follows:

"2. Goods, other than live animals, in transit without transhipment shall not be subject to health measures or detained at any port, airport, or frontier."

PART V - SPECIAL PROVISIONS RELATING TO EACH OF THE DISEASES SUBJECT TO THE REGULATIONS

Chapter IV - Smallpox

Delete, and renumber Article 83 and succeeding articles accordingly, throughout the Regulations.

PART VI - HEALTH DOCUMENTS

Appendix 3 - International Certificate of Vaccination or Revaccination against Smallpox

Delete, and renumber Appendices 4 and 5 accordingly, throughout the Regulations.

Appendix 4 - Maritime Declaration of Health

Health questions, No. 1. Delete the word "smallpox" so that the question reads as follows:

"1. Has there been on board during the voyage* any case or suspected case of plague, cholera, or yellow fever?
Give particulars in Schedule.

* If more than four weeks have elapsed since the voyage began, it will suffice to give particulars for the last four weeks." /Footnote unchanged./

ARTICLE II

The period provided, in the execution of Article 22 of the Constitution of the Organization, for rejection or reservation shall be six months from the date of the notification by the Director-General of the adoption of these Additional Regulations by the World Health Assembly.

ARTICLE III

These Additional Regulations shall come into force on the first day of January 1982.

ARTICLE IV

The following final provisions of the International Health Regulations (1969) shall apply to these Additional Regulations: paragraph 3 of Article 94; paragraphs 1 and 2 and the first sentence of paragraph 5 of Article 95; Article 96; Article 97, substituting the date mentioned in Article III of these Additional Regulations for that mentioned therein; and Articles 98 to 101 inclusive.

IN FAITH WHEREOF we have set our hands at Geneva this twentieth day of May 1981.

(signed) Dr M. VIOLAKI-PARASKEVA

President of the
Thirty-fourth World Health Assembly

(signed) H. MAHLER

Director-General of the
World Health Organization

(Fourteenth plenary meeting, 20 May 1981 - Committee B, third report)

WHA34.14 Organizational study on the role of WHO in training in public health and health programme management, including the use of country health programming

The Thirty-fourth World Health Assembly,

Having examined the Executive Board's report on its organizational study on the role of WHO in training in public health and health programme management, including the use of country health programming;[1]

Reaffirming resolutions WHA23.61, WHA26.35, WHA28.88, WHA29.72, WHA31.12, WHA31.43 and WHA32.30 concerning the development of national health service systems and primary health care, and the need for suitable management methods and a unified managerial process for national health development and training;

Recognizing that, to reorient their health systems towards the attainment of the social goal of health for all by the year 2000, countries will have to apply a systematic managerial process for national health development;

Convinced that the development and application of a systematic managerial process depend on political will as well as on appropriate managerial competencies, and that such competencies can be generated through appropriate and systematized management training activities;

Noting the experience in management training accumulated by a number of countries, as well as the experience of WHO;

Recognizing that the strengthening of management and related training forms an integral part of the Global Strategy for health for all by the year 2000;

1. CONGRATULATES the Executive Board on its study;

2. ENDORSES its conclusions and recommendations;

3. URGES Member States to include, as essential components of their strategies for health for all by the year 2000, strategies for strengthening management and management training for the various categories of personnel and for developing suitable career structures for those trained and, as part of these strategies:

(1) to identify their specific needs for training in health management, and to appraise, as a matter of urgency, the status of their management training resources, both human and material;

(2) to establish a permanent mechanism, including the organization of a national network for health development, as appropriate, for developing, applying, and providing training in the managerial process for national health development and related health services research;

(3) to develop appropriate training activities in health management, including the provision of in-service training in institutions that are developing and applying the country's managerial process for health development, and the strengthening of the management training component of basic, postbasic, and continuing education programmes for health personnel, including schools of public health, medicine, nursing, other health personnel and teacher training centres;

4. REQUESTS the regional committees to review the implications of the study's findings for their respective regions and to develop, in support of national efforts, regional strategies for the implementation of the study's recommendations;

[1] Document EB67/1981/REC/1, Annex 5.

5. REQUESTS the Director-General:

(1) to implement, as part of WHO's role in implementing the global strategy for health for all, a coherent strategy in support of training in health management, along the lines proposed in the Executive Board's report;

(2) to facilitate technical cooperation among developing countries and foster cooperation between developed and developing countries in this area;

(3) to seek extrabudgetary funds for this purpose, and to assist in channelling bilateral and other funds to where the needs are greatest;

6. REQUESTS the Executive Board to monitor progress in the implementation of the recommendations of the study.

Hbk Res., Vol. II (4th ed.), 3.2.7

(Fourteenth plenary meeting, 20 May 1981 - Committee B, third report)

WHA34.15 Recruitment of international staff in WHO

The Thirty-fourth World Health Assembly,

Noting the report and proposals of the Director-General[1] and the views of the Executive Board with regard to the recruitment of international staff in WHO;

Recalling resolution WHA33.30 and the earlier resolutions of the Health Assembly, the Executive Board and the United Nations General Assembly mentioned therein;

Considering also resolution 35/210 of the United Nations General Assembly;

Recalling Article 35 of the Constitution, which states that the paramount consideration in the employment of the staff shall be to assure that the efficiency, integrity and internationally representative character of the Secretariat shall be maintained at the highest level, with due regard being paid also to the importance of recruiting the staff on as wide a geographical basis as possible; and convinced that this is compatible with the principle of equitable geographical distribution;

Emphasizing the Director-General's prerogative to appoint the staff of the Secretariat under the authority conferred upon him by the same article of the Constitution and the Staff Regulations established by the Health Assembly;

Concerned that an imbalance in the geographical distribution of the professional and higher graded staff of the Organization continues to exist despite the progress made by the Director-General in achieving a more balanced and equitable distribution of such staff;

Concerned by the fact that the proportion of women on the staff has not increased, and noting that Member States propose very few women candidates for consideration;

1. REQUESTS the Director-General to modify the method of calculating desirable ranges in line with that adopted by the United Nations General Assembly, taking into account WHO's membership and the size of its Secretariat;

[1] Document EB67/1981/REC/1, Annex 12.

2. REQUESTS the Executive Board to review the question of desirable ranges after the United Nations General Assembly has done so at its forty-first session, and to report thereon to the Health Assembly;

3. ESTABLISHES a target of 40% of all vacancies arising in professional and higher graded posts subject to geographical distribution during the period 1981-1982 for the appointment of nationals of unrepresented and under-represented countries, in order to ensure that such countries achieve or more closely attain their desirable range in that period, while ensuring that those countries already within their desirable range remain adequately represented;

4. REQUESTS the Director-General, while nevertheless reaffirming that no post should automatically be considered the exclusive preserve of any Member State, to continue to permit replacement of separated incumbents by candidates of the same nationality within a reasonable time frame whenever this is necessary to ensure that the representation of Member States whose nationals serve primarily on fixed-term contracts is not adversely affected;

5. CALLS UPON the Director-General:

(1) to pursue and intensify his efforts to appoint more women to the staff of WHO, particularly at senior levels;

(2) to include information thereon in his annual reports to the Executive Board and the Health Assembly;

(3) to review the reasons for the apparently insufficient availability of women candidates;

6. URGES Member States to assist the Director-General's efforts to increase the number of women on the staff by proposing a considerably higher proportion of well-qualified women candidates;

7. DECIDES to maintain the presently existing policy regarding career service appointments, which limits the award of such appointments to the minimum required by the Organization's programme, pending the outcome of the studies on this matter requested by the United Nations General Assembly;

8. REQUESTS the Director-General to continue and intensify his efforts to further improve procedures for the recruitment of international staff subject to geographical distribution, keeping in mind the practice of the United Nations.

Hbk Res., Vol. II (4th ed.), 6.2.2

(Fourteenth plenary meeting, 20 May 1981 - Committee B, third report)

WHA34.16 Appropriation Resolution for the financial period 1982-1983

The Thirty-fourth World Health Assembly

RESOLVES to appropriate for the financial period 1982-1983 an amount of US$ 522 933 500 as follows:

A.

Appropriation section	Purpose of appropriation	Amount US$
1.	Policy organs	9 615 200
2.	General programme development, management and coordination	63 362 100
3.	Development of comprehensive health services	88 493 400
4.	Disease prevention and control	86 054 200
5.	Promotion of environmental health	30 927 800
6.	Health manpower development	60 056 100
7.	Health information	44 525 900
8.	General services and support programmes	85 865 300
	Effective working budget	468 900 000
9.	Transfer to Tax Equalization Fund	44 000 000
10.	Undistributed reserve	10 033 500
	Total	522 933 500

B. Amounts not exceeding the appropriations voted under paragraph A shall be available for the payment of obligations incurred during the financial period 1 January 1982 - 31 December 1983 in accordance with the provisions of the Financial Regulations. Notwithstanding the provisions of the present paragraph, the Director-General shall limit the obligations to be incurred during the financial period 1982-1983 to sections 1-9.

C. Notwithstanding the provisions of Financial Regulation 4.5, the Director-General is authorized to make transfers between those appropriation sections that constitute the effective working budget up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made, this percentage being established in respect of section 2 exclusive of the provision made for the Director-General's and Regional Directors' Development Programmes (US$ 7 780 300). The Director-General is also authorized to apply amounts not exceeding the provision for the Director-General's and Regional Directors' Development Programmes to those sections of the effective working budget under which the programme expenditure will be incurred. All such transfers shall be reported in the financial report for the financial period 1982-1983. Any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.5.

D. The appropriations voted under paragraph A shall be financed by assessments on Members after deduction of the following:

	US$
(i) reimbursement of programme support costs by the United Nations Development Programme in the estimated amount of	4 600 000
(ii) casual income in the amount of	24 400 000
	29 000 000

thus resulting in assessments on Members of US$ 493 933 500. In establishing the amounts of contributions to be paid by individual Members, their assessments shall be reduced further by the amount standing to their credit in the Tax Equalization Fund, except that the credits of those Members that require staff members of WHO to pay taxes on their WHO emoluments shall be reduced by the estimated amounts of such tax reimbursements to be made by the Organization.

Hbk Res., Vol. II (4th ed.), 2.3.10

(Fourteenth plenary meeting, 20 May 1981 - Committee A, first report)

WHA34.17 Programme support costs

The Thirty-fourth World Health Assembly,

Having considered the report of the Director-General on collaboration with the United Nations system, with particular reference to programme support costs,[1] and the Executive Board's recommendations thereon;

Recalling resolution WHA27.33 and previous resolutions dealing with policy questions relating to the financing of programme support costs incurred by the Organization in respect of activities financed from extrabudgetary funds;

Recalling further that, according to a special cost measurement exercise undertaken in 1973, the cost of technical and non-technical support and services for technical cooperation projects financed by the United Nations Development Programme and executed by WHO approximated to 27% of project expenditures;

Having noted the decisions and recommendations adopted on this subject during 1980 by the Governing Council of the United Nations Development Programme (decision 80/44) and endorsed by the Economic and Social Council (resolution 1980/65);

Having noted further the decision in this respect of the United Nations General Assembly in its resolution 35/217;

1. ENDORSES the new formula approved by the United Nations General Assembly for the reimbursement by the United Nations Development Programme, as from 1982, of support costs relating to operational activities financed by the United Nations Development Programme and by other similar programmes or funds under the jurisdiction of its Governing Council, such reimbursement to be made at the standard rate of 13% of annual project expenditures;

2. DECIDES that, in the interest of consistency and uniformity of application throughout the United Nations system, a standard 13% charge in partial reimbursement for the cost of related technical and non-technical support and services shall be made by the Organization as from 1982 on technical cooperation project expenditures incurred under all other extrabudgetary sources of funds, including trust funds or similar funds, except that account will be taken of special WHO programmes financed from several sources of funds in which provision for the cost of the required support and services is already included in the budgets for such activities;

3. CONFIRMS that the structure, staffing and working methods of the Organization are being regularly reviewed, and that this has already resulted in the transfer of considerable financial resources from establishment and administrative costs to increased technical cooperation with and services to governments;

4. AUTHORIZES the Director-General, upon request, to furnish to funding agencies and donors such information on programme support costs as might already be largely available, for example, in the biennial programme budget, the financial report, or any other report or documentation submitted to the Executive Board or the Health Assembly from time to time.

Hbk Res., Vol. II (4th ed.), 7.1.2

(Fourteenth plenary meeting, 20 May 1981 - Committee B, fourth report)

[1] Document EB67/1981/REC/1, Annex 10.

WHA34.18 Emergency health and medical assistance to Democratic Yemen, Djibouti, Ethiopia and Somalia

The Thirty-fourth World Health Assembly,

Noting with grave concern the serious flood situation in Democratic Yemen, Djibouti, Ethiopia and Somalia;

Aware of the health and medical assistance urgently required by the Governments of Democratic Yemen, Djibouti, Ethiopia and Somalia to cope with the situation;

1. CONSIDERS that the serious health and medical problems arising from heavy rains and floods which have now created a disaster situation constitute a source of major concern to the international community, thereby necessitating urgent and substantial health and medical assistance to the Governments of Democratic Yemen, Djibouti, Ethiopia and Somalia;

2. REQUESTS the Director-General to mobilize on an emergency basis health and medical assistance programmes for the Governments of Democratic Yemen, Djibouti, Ethiopia, and Somalia, and allocate the necessary funds for this purpose to the best extent possible;

3. CALLS upon the specialized agencies and other United Nations agencies concerned, as well as all governmental and nongovernmental organizations, to cooperate with WHO in this field.

Hbk Res., Vol. II (4th ed.), 1.2.2.3

(Fourteenth plenary meeting, 20 May 1981 - Committee B, fourth report)

WHA34.19 Health conditions of the Arab population in the occupied Arab territories, including Palestine

The Thirty-fourth World Health Assembly,

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

Aware of its responsibility for ensuring proper health conditions for all peoples who suffer from exceptional situations, including foreign occupation and especially settler colonialism;

Bearing in mind that the WHO Constitution provides that "health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity";

Affirming the principle that the acquisition of territories by force is inadmissible and that any occupation of territories by force gravely affects the health, psychological, mental and physical conditions of the population under occupation, and that this can 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 (XXXVII), 1981, adopted by the Commission on Human Rights, which condemns Israel's violations of human rights in occupied Arab territories, including Palestine;

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

I

REQUESTS the Director-General to increase collaboration and coordination with the Palestine Liberation Organization concerning necessary assistance to the Palestinian people;

II

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

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

1. REQUESTS States to increase their contribution to enable the Agency to continue carrying out the tasks assigned to it;

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

III

1. EXPRESSES its deep concern at the poor health and psychological conditions suffered by the inhabitants of the occupied Arab territories, including Palestine, and condemns Israel's attempts to incorporate Arab health institutions into the occupation authorities' institutions;

2. 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. CONDEMNS the establishment of Israeli settlements in the occupied Arab territories, including Palestine, and the illicit exploitation of natural wealth and resources of the Arab inhabitants in those territories, especially the confiscation of Arab water sources and their diversion for the purposes of occupation and settlement;

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

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

6. CONDEMNS Israel for its refusal to implement resolutions of the Health Assembly and other international organizations calling upon it to allow refugees and displaced persons to return to their homes;

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

8. ENDORSES the opinion of the Special Committee of Experts that "the socioeconomic situation of a population and its state of health are closely related"[1] and that the sociopolitical situation existing in the occupied Arab territories, including Palestine, is favourable neither to the improvement of the state of health of the population concerned nor to the full development of services adapted to the promotion of human welfare;

9. CONDEMNS Israel for not allowing the Special Committee freedom to carry out its tasks according to Health Assembly resolution WHA33.18, especially with respect to visiting prisoners;

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

Hbk Res., Vol. II (4th ed.), 7.1.4.4

(Fourteenth plenary meeting, 20 May 1981 - Committee B, fourth report)

WHA34.20 Health assistance to refugees and displaced persons in Cyprus

The Thirty-fourth World Health Assembly,

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

Recalling resolutions WHA28.47, WHA29.44, WHA30.26, WHA31.25, WHA32.18 and WHA33.22;

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

Considering that the continuing health problems of the refugees and displaced persons in Cyprus call for further assistance;

1. NOTES with satisfaction the information provided by the Director-General on health assistance to refugees and displaced persons in Cyprus;

2. EXPRESSES its appreciation for all the efforts of the Coordinator of United Nations Humanitarian Assistance in Cyprus to obtain the funds necessary for the Organization's action to meet the health needs of the population of Cyprus;

3. REQUESTS the Director-General to continue and intensify health assistance to refugees and displaced persons in Cyprus, in addition to any assistance made available within the framework of the efforts of the Coordinator of United Nations Humanitarian Assistance in Cyprus, and to report to the Thirty-fifth World Health Assembly on such assistance.

Hbk Res., Vol. II (4th ed.), 7.1.4.5

(Fifteenth plenary meeting, 21 May 1981 - Committee B, fifth report)

[1] Document A34/17, para. 4.

WHA34.21 Health and medical assistance to Lebanon

The Thirty-fourth World Health Assembly,

Recalling resolutions WHA29.40, WHA30.27, WHA31.26, WHA32.19 and WHA33.23 on health and medical assistance to Lebanon;

Taking note of United Nations General Assembly resolutions 33/146 of 20 December 1978, 34/135 of 14 December 1979 and 35/85 of 5 December 1980 on international assistance for the reconstruction and development of Lebanon, calling on the specialized agencies, organs and other bodies of the United Nations to intensify their efforts in this field;

Having examined the Director-General's report[1] on the action taken by WHO, in cooperation with other international bodies, for emergency health and medical assistance to Lebanon in 1980-1981;

Taking note of the health and medical assistance provided by the Organization to Lebanon during 1980-1981;

1. EXPRESSES its appreciation to the Director-General for his efforts;

2. EXPRESSES also its appreciation to all the international agencies, organs and bodies of the United Nations and to all governmental and nongovernmental organizations for their cooperation with WHO in this regard;

3. CONSIDERS that the growing health and medical problems in Lebanon, which have attained lately a critical level, constitute a source of great concern and thereby necessitate a continuation and a substantial intensification of health and medical assistance to Lebanon;

4. REQUESTS the Director-General to continue and intensify substantially the Organization's health and medical assistance to Lebanon and to allocate for this purpose, and to the best extent possible, funds from the regular budget and other financial resources;

5. CALLS UPON the specialized agencies, organs and bodies of the United Nations, and on all governmental and nongovernmental organizations, to intensify their cooperation with WHO in this field;

6. REQUESTS the Director-General to report to the Thirty-fifth World Health Assembly on the implementation of this resolution.

Hbk Res., Vol. II (4th ed.), 1.2.2.3

(Fifteenth plenary meeting, 21 May 1981 - Committee B, fifth report)

WHA34.22 International Code of Marketing of Breast-milk Substitutes

The Thirty-fourth World Health Assembly,

Recognizing the importance of sound infant and young child nutrition for the future health and development of the child and adult;

Recalling that breast-feeding is the only natural method of infant feeding and that it must be actively protected and promoted in all countries;

Convinced that governments of Member States have important responsibilities and a prime role to play in the protection and promotion of breast-feeding as a means of improving infant and young child health;

[1] Document A34/20.

Aware of the direct and indirect effects of marketing practices for breast-milk substitutes on infant feeding practices;

Convinced that the protection and promotion of infant feeding, including the regulation of the marketing of breast-milk substitutes, affect infant and young child health directly and profoundly, and are a problem of direct concern to WHO;

Having considered the draft International Code of Marketing of Breast-milk Substitutes prepared by the Director-General and forwarded to it by the Executive Board;

Expressing its gratitude to the Director-General and to the Executive Director of the United Nations Children's Fund for the steps they have taken in ensuring close consultation with Member States and with all other parties concerned in the process of preparing the draft International Code;

Having considered the recommendation made thereon by the Executive Board at its sixty-seventh session;

Confirming resolution WHA33.32, including the endorsement in their entirety of the statement and recommendations made by the joint WHO/UNICEF Meeting on Infant and Young Child Feeding held from 9 to 12 October 1979;

Stressing that the adoption of and adherence to the International Code of Marketing of Breast-milk Substitutes is a minimum requirement and only one of several important actions required in order to protect healthy practices in respect of infant and young child feeding;

1. ADOPTS, in the sense of Article 23 of the Constitution, the International Code of Marketing of Breast-milk Substitutes annexed to the present resolution;[1]

2. URGES all Member States:

(1) to give full and unanimous support to the implementation of the recommendations made by the joint WHO/UNICEF Meeting on Infant and Young Child Feeding and of the provisions of the International Code in its entirety as an expression of the collective will of the membership of the World Health Organization;

(2) to translate the International Code into national legislation, regulations or other suitable measures;

(3) to involve all concerned social and economic sectors and all other concerned parties in the implementation of the International Code and in the observance of the provisions thereof;

(4) to monitor the compliance with the Code;

3. DECIDES that the follow-up to and review of the implementation of this resolution shall be undertaken by regional committees, the Executive Board and the Health Assembly in the spirit of resolution WHA33.17;

4. REQUESTS the FAO/WHO Codex Alimentarius Commission to give full consideration, within the framework of its operational mandate, to action it might take to improve the quality standards of infant foods, and to support and promote the implementation of the International Code;

5. REQUESTS the Director-General:

(1) to give all possible support to Member States, as and when requested, for the implementation of the International Code, and in particular in the preparation of national legislation and other measures related thereto in accordance with operative subparagraph 6(6) of resolution WHA33.32;

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[1] See Annex 3.

(2) to use his good offices for the continued cooperation with all parties concerned in the implementation and monitoring of the International Code at country, regional and global levels;

(3) to report to the Thirty-sixth World Health Assembly on the status of compliance with and implementation of the Code at country, regional and global levels;

(4) based on the conclusions of the status report, to make proposals, if necessary, for revision of the text of the Code and for the measures needed for its effective application.

Hbk Res., Vol. II (4th ed.), 1.9.1 (Fifteenth plenary meeting, 21 May 1981 - Committee A, second report)

WHA34.23 Nutritional value and safety of products specifically intended for infant and young child feeding

The Thirty-fourth World Health Assembly,

Recalling resolutions WHA27.43, WHA28.42, WHA31.55, and in particular WHA33.32 concerning infant and young child feeding;

Stressing the urgent need to make the best use of scientific knowledge and available technologies to manufacture and make available, for those infants and young children who need such products, suitable food products of the highest possible quality;

Aware that storage conditions affect the degree to which the nutritional value and safety of products specifically intended for infant and young child feeding are preserved;

Noting the unavailability at the present time of adequate information concerning the effects of storage and distribution, over a period of time and under different climatic conditions, on the nutritional value and safety of such products;

Recognizing the essential need for Member States to possess such information so as to enable them to take suitable measures to protect the nutritional value of such products;

1. REQUESTS the Director-General to initiate studies to assess the changes that occur over a period of time under various climatic conditions, particularly in arid and tropical regions, and under the prevailing storage and distribution arrangements, in the quality, nutritional value and safety of products specifically intended for infant and young child feeding;

2. URGES Member States, the United Nations Children's Fund and the Food and Agriculture Organization of the United Nations, as well as all the other international, governmental and nongovernmental organizations concerned, to cooperate actively with WHO for the successful carrying out of these studies;

3. INVITES Member States to make voluntary contributions to enable the speedy launching of the studies;

4. REQUESTS the Director-General to submit a report on the results of his efforts to the Thirty-sixth World Health Assembly.

Hbk Res., Vol. II (4th ed.), 1.9.1 (Fifteenth plenary meeting, 21 May 1981 - Committee A, second report)

WHA34.24 The meaning of WHO's international health work through coordination and technical cooperation

The Thirty-fourth World Health Assembly,

Recalling previous resolutions of the Health Assembly, and in particular resolutions WHA23.59 on certain important constitutional functions of WHO; WHA28.75 and WHA28.76 on technical assistance; WHA29.48, WHA30.30, WHA31.41 and WHA32.27 on technical cooperation, technical cooperation among developing countries, and related programme budget policy; WHA32.24 on coordination for health, socioeconomic development and peace; and WHA30.43, WHA32.30 and WHA33.24 on policies and strategies for 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;

Resolved to strengthen further cooperation among Member States, being guided by the Constitution of WHO for the attainment by all peoples of the highest possible level of health, by the Declaration and recommendations of Alma-Ata on primary health care as the key to the attainment of health for all, and by resolution 34/58 of the United Nations General Assembly on health as an integral part of development;

Resolutely determined to fulfil the constitutional functions of WHO as the directing and coordinating authority on international health work through the collective action of its Member States, and through ensuring technical cooperation with its Member States at their request;

Welcoming the changed climate in WHO and among its Member States which has given rise to the rejection of the concept of "technical assistance", whereby aid was provided by so-called "donors" to "recipients", and its replacement by the concept of "technical cooperation" founded on common and mutual interest of all, whereby Member States cooperate with their Organization, as equal partners, to define and achieve their health goals through programmes that are determined by their needs and priorities and that promote their self-reliance in health development;

1. REITERATES that WHO's unique constitutional role in international health work comprises in essence the inseparable and mutually supportive functions of acting as the directing and coordinating authority on international health work and ensuring technical cooperation between WHO and its Member States, essential for the attainment of health for all by the year 2000, making no distinction between these integral functions carried out at country, regional and global levels, whether financed from the WHO regular budget or from other sources;

2. AFFIRMS that:

(1) coordination in international health work is the facilitation of the collective action of Member States and WHO to identify health problems throughout the world, to formulate policies for solving them, and to define principles and develop strategies for giving effect to these policies;

(2) technical cooperation in international health work is joint action of Member States cooperating among themselves and with WHO, as well as with other relevant agencies, to achieve their common goal of the attainment by all people of the highest possible level of health by implementing the policies and strategies they have defined collectively;

3. CONSIDERS further that technical cooperation in international health work must be characterized by:

(1) equal partnership among cooperating parties, developing and developed countries alike, WHO and other intergovernmental, bilateral, multilateral and nongovernmental organizations participating in technical cooperation;

(2) respect for the sovereign right of every country to develop its national health system and services in the way that it finds most rational and appropriate to its needs;

to mobilize and use all internal as well as bilateral and other resources to this end; and, for this purpose, to make use of scientific, technical, human, material, information and other support provided by WHO and other partners in health development;

(3) mutual responsibility of cooperating parties for carrying out jointly agreed decisions and obligations, exchanging experience and evaluating results obtained, both positive and negative, and making the information thus generated available for the use and benefit of all;

4. STRESSES the responsibility of WHO to fulfil its constitutional leadership role as the directing and coordinating authority in international health work, including research promotion and development; the application of science and technology for health; policy formulation; the development of worldwide health programmes for the promotion of health, prevention, control and diagnosis of disease, rehabilitation and strengthening of health systems; the provision of valid information on health matters; the fostering of mechanisms for technical cooperation and coordination in health work; the mobilization and rationalization of the flow of health resources; the contribution of health to socioeconomic development and peace; and the provision of necessary support for the development of policies, strategies and plans of action at country, regional, interregional and global levels, including joint action with other relevant international organizations;

5. URGES Member States:

(1) to act collectively in order to ensure the most effective fulfilment by WHO of its constitutional functions and the formulation by the Organization of appropriate international health policies, and principles and programmes to implement these policies;

(2) to formulate their requests for technical cooperation with WHO in the spirit of the policies, principles and programmes they have adopted collectively in WHO;

(3) to take full account of the experiences of technical cooperation between WHO and its Member States when deciding collectively on policies, principles and programmes in WHO;

6. REQUESTS the Executive Board to ensure that the Organization's general programmes of work, medium-term programmes and programme budgets fully reflect WHO's international health work as a properly balanced and mutually reinforcing combination of the Organization's constitutional functions of coordination and technical cooperation;

7. REQUESTS the Director-General:

(1) to emphasize WHO's unique constitutional role in international health work in all appropriate forums, and particularly in the United Nations system and other international and bilateral organizations;

(2) to report to the Board on any difficulties encountered in implementing this resolution and, in particular, in gaining acceptance of the concept of WHO's international health work as described in the resolution;

8. INVITES the United Nations organizations concerned, as well as other international and bilateral organizations and collaborating centres and institutions, to coordinate with and support the efforts of WHO by appropriate actions within their respective spheres of competence in the spirit of resolution 34/58 of the United Nations General Assembly on health as an integral part of development, and in so doing to adhere to the principles of technical cooperation and coordination in international health work set forth in this resolution.

Hbk Res., Vol. II (4th ed.), 1.2.1

(Sixteenth plenary meeting, 22 May 1981 - Committee A, third report)

WHA34.25 International Drinking Water Supply and Sanitation Decade

The Thirty-fourth World Health Assembly,

Having considered the report[1] of the Director-General relating to the International Drinking Water Supply and Sanitation Decade (1981-1990);

Stressing that the provision of safe drinking water and sanitation services is one of the essential elements of primary health care, and one of the essential global targets for health for all;

Noting with concern that progress made in the 1970s in improving drinking water and sanitation services was slower than expected;

Considering that wide acceptance by Member States of the International Drinking Water Supply and Sanitation Decade offers a new incentive to provide people with these essential services; and that maximum use should be made of all opportunities afforded by the Decade to promote the attainment of health for all;

Recognizing the need to monitor specific measurable indicators of the impact on health of improved water supplies and sanitation developed during the Decade, so as to help mobilize the substantial necessary resources, foster community participation and further encourage international support for that programme;

Aware that the Decade presents an opportunity to eliminate dracunculiasis (Guinea worm disease) as a public health problem in affected areas, where the prevalence of the disease could serve as a uniquely visible and measurable indicator of progress for the Decade;

Restating the principles[2] endorsed by the Thirty-third World Health Assembly that Decade efforts will contribute to health for all through:

- complementarity of sanitation and water supply development;
- focus on both rural and urban underserved populations in policies and programmes;
- achievement of full coverage through replicable, self-reliant and self-sustaining programmes;
- use of socially relevant systems applying an appropriate technology;
- association of the community with all stages of programmes and projects;
- close relation of water supply and sanitation programmes with those in other sectors;
- association of water supply and sanitation with other health programmes;

1. NOTES with appreciation the report of the Director-General;

2. RECOMMENDS that Member States:

(1) accelerate substantially the pace of their programmes for drinking-water supply and sanitation through the adoption of relevant policies and their implementation through plans aimed at covering the total population;

(2) strengthen or establish suitable mechanisms, such as national action committees, to facilitate policy formulation, the elaboration of national Decade plans, the strengthening of relevant programmes of all involved national agencies and their active participation at all levels, and the best use of available external resources, recognizing the UNDP resident representatives as focal points for international action at the country level;

[1] Document A34/4.

[2] Document A33/15.

(3) focus programmes on their national priority health problems and monitor the resulting impact on health, giving particular attention to the reduction of diarrhoeal diseases and, in specifically affected countries, to other preventable water- or sanitation-related infections such as schistosomiasis and dracunculiasis;

(4) incorporate activities for the improvement of drinking-water supply and sanitation services into their national programmes for primary health care, particularly in respect of people's education and involvement, training of community workers, and strengthening the support capacity at all levels of referral;

(5) strengthen the ability of national health agencies to take an active part in planning and implementing programmes for the Decade;

3. FURTHER RECOMMENDS that Member States:

(1) promote the International Drinking Water Supply and Sanitation Decade in international intergovernmental organizations in such a way as to make coordination more effective at the country level;

(2) propose relevant water supply and sanitation programmes and projects for external support in a manner consistent with the principles set forth above;

4. INVITES the multilateral and bilateral agencies concerned to support national plans by giving priority to programmes and projects consistent with the above principles;

5. REQUESTS the Director-General:

(1) to further develop and implement WHO's strategy of support of the Decade in conformity with resolutions WHA29.47, WHA30.33, WHA31.40 and WHA32.11, as well as decision WHA33(17) of the Thirty-third World Health Assembly;

(2) to ensure the effective fulfilment by WHO of its central technical role with respect to the International Decade, including support to the coordinating mechanisms of the United Nations system and continued collaboration with Member countries to specify achievable health-related targets for the Decade;

(3) to cooperate with Member States, the other agencies in the United Nations system, and the multilateral and bilateral agencies concerned, in exchanging information and facilitating support to relevant projects and programmes for which external resources are sought;

(4) to cooperate with Member States in assessing experience accruing from the implementation of national programmes and, particularly, information pertaining to the impact of these programmes on the health of communities, and to disseminate this information widely among Member States, the other agencies of the United Nations system, and multilateral and bilateral agencies;

(5) to report on these matters periodically to future Health Assemblies during the Decade.

Hbk Res., Vol. II (4th ed.), 1.14.2.1

(Sixteenth plenary meeting, 22 May 1981 - Committee A, third report)

WHA34.26 Promotion of prevention of adverse health effects of disasters and emergencies through preparedness

The Thirty-fourth World Health Assembly,

Recalling resolutions EB51.R43, EB55.R62 and WHA28.48 on the role of the World Health Organization in emergencies and disasters;

Noting that a great number of Member States, in particular developing countries in view of their socioeconomic situation, are vulnerable to the effects of disasters;

Recognizing that sudden calamities and disasters adversely affect a country's health services and impede its development;

Stressing that, despite the undoubted importance of relief in emergencies, preventive measures and preparedness are of fundamental importance;

Reaffirming that the Organization should assume a leadership role in the health aspects of disaster preparedness;

1. COMMENDS the Director-General for his valuable efforts in providing and coordinating emergency relief for disaster-stricken countries;

2. URGES Member States to strengthen the Organization's role in all health aspects of disasters and to increase their direct cooperation with countries at risk;

3. REQUESTS the Director-General, while continuing the Organization's useful emergency action, to strengthen its capacity and increase its resources, whether from budgetary or extrabudgetary sources, with a view to promoting the development of approaches to the prevention of adverse health effects of disasters, when possible, and the preparadness of Member.States to deal with disasters, to participate in the coordination of aid, and to report on the matter to future Health Assemblies.

Hbk Res., Vol. II (4th ed.), 1.2.2.3

(Sixteenth plenary meeting, 22 May 1981 - Committee A, third report)

WHA34.27 Use of SI units in medicine: use of the kilopascal for blood pressure measurement

The Thirty-fourth World Health Assembly,

Having considered the international difficulties being encountered in attempting to introduce the kilopascal, a unit of the Système international d'Unités (SI), for the measurement of blood pressure;

Noting the attitudes and resolutions of international scientific bodies objecting to the precipitate replacement of the millimetre of mercury by the kilopascal;

Further noting with concern the ensuing difficulties encountered in communication between the scientific community and the population in a number of Member States;

Mindful, nevertheless, of the desirability of a unified international system of units as expressed in earlier resolutions;

Considering the high prevalence of hypertension, its deleterious effect, and the high probability of preventing it by early screening;

Recalling the caution expressed in resolutions WHA29.65 and WHA30.39 regarding the difficulties that might arise through the precipitate introduction into medical practice of certain units of the SI, with particular reference to the substitution of the kilopascal for the millimetre of mercury in the measurement of blood pressure;

1. CONSIDERS that there is no compelling need to replace the millimetre of mercury by the kilopascal in medical practice at the present time;

2. RECOMMENDS that the millimetre of mercury and the kilopascal be used simultaneously until a future Health Assembly considers the retention of the millimetre of mercury unnecessary for the undisturbed delivery of health care and the interchange of scientific information;

3. REQUESTS the Director-General to draw attention to the present resolution in the Organization's journals as well as through the media of the relevant nongovernmental organizations.

Hbk Res., Vol. II (4th ed.), 1.16.6

(Sixteenth plenary meeting, 22 May 1981 - Committee A, third report)

WHA34.28 Periodicity of Health Assemblies

The Thirty-fourth World Health Assembly,

Recalling resolution WHA12.38, which affirms that "notwithstanding any savings that might accrue, it would not be opportune, at a time when the Organization is expanding and its activities developing, to reduce the number of occasions upon which the World Health Assembly would have the opportunity to direct and control such expansion and activities";

Having in mind the need to preserve and strengthen the democratic participation of all Member States in the work of the Organization;

Having considered the views expressed by the regional committees, the discussions at the sixty-seventh session of the Executive Board, and the Director-General's report on the periodicity and duration of Health Assemblies;[1]

Recognizing that the implementation of the plan of action consequent upon the study of the structures of the Organization in the light of its functions is still incomplete;

Keeping in mind, at all times, the collective commitment of all countries to achieve the goal of health for all by the year 2000 and the consequential need to further strengthen the role of the Assembly as the highest forum of the Organization;

Taking into account the positive experience of the long-time practice of annual Assemblies, and realizing that any change in the current system and change-over from annual to biennial Assemblies without accompanying consequential arrangements as regards the composition and size of the Executive Board and the role and function of all bodies of the Organization will have adverse implications for the attainment of regional and global commitments, besides reflecting upon effective fulfilment of the constitutional functions of the Assembly;

1. CONSIDERS that a change in the periodicity of Health Assemblies should only take place in connexion with other structural reforms, such as changes in the composition and size of the Executive Board and in the role and function of all bodies of the Organization;

2. RESOLVES to retain the practice of annual Assemblies for the time being.

Hbk Res., Vol II (4th ed.), 3.1.1.3

(Sixteenth plenary meeting, 22 May 1981 - Committee B, sixth report)

[1] Document EB67/1981/REC/1, Annex 13.

WHA34.29 Duration and method of work of Health Assemblies

The Thirty-fourth World Health Assembly,

Having considered the reports and recommendations of the Executive Board and the Director-General on the periodicity and duration of Health Assemblies;[1]

Recalling resolution WHA33.19, which expressed the belief that Health Assemblies in even-numbered years should be limited to not more than two weeks' duration;

1. DECIDES that, commencing in 1982, the duration of the Health Assembly shall be limited to not more than two weeks in even-numbered years, when there is not a proposed programme budget to consider;

2. REQUESTS the Executive Board to elaborate the necessary methods of work for implementation on a trial basis at the Thirty-fifth World Health Assembly;

3. REQUESTS the Director-General and the Executive Board to submit a report on the results of the trial, in respect of both the methods of work and the duration of the Health Assembly, to the Thirty-sixth World Health Assembly for its consideration.

Hbk Res., Vol. II (4th ed.), 3.1.1.2; 3.1.3 (Sixteenth plenary meeting, 22 May 1981 - Committee B, sixth report)

WHA34.30 International Year of Disabled Persons, 1981: WHO's cooperative activities within the United Nations system for disability prevention and rehabilitation

The Thirty-fourth World Health Assembly,

Recalling resolution 31/123 of the United Nations General Assembly proclaiming the year 1981 as the International Year of Disabled Persons;

Recalling resolution WHA31.39 requesting the Director-General to contribute extensively to the success of the International Year;

Considering that the disabled, rather than being a load on society and nations, should benefit from the efforts for prevention, treatment, readaptation and rehabilitation, so as to be able to share effectively in the normal activities of society;

Noting that, in addition to malnutrition, communicable diseases, poor quality of care, and traffic and work accidents, wars, armed aggressions, torture and the suppression of fundamental human rights constitute factors in the considerably increasing number of physically, psycho-traumatically and mentally disabled persons;

Noting the efforts deployed by the Director-General in favour of the disabled:

1. CONGRATULATES the Director-General for his report[2] and on the action already taken;

2. RECOMMENDS that Member States:

(1) continue and increase their efforts to ensure the success of the International Year of Disabled Persons;

[1] Document EB67/1981/REC/1, Annex 13.

[2] Document EB67/1981/REC/1, Annex 14.

(2) build on these efforts and develop permanent programmes that would benefit the disabled, as an integral part of activities towards the goal of health for all by the year 2000;

3. REQUESTS the Director-General:

(1) to collaborate with Member States in supporting programmes of disability prevention and rehabilitation within the primary health care context, especially in developing countries;

(2) to enhance cooperation with other United Nations agencies, regional intergovernmental organizations and international nongovernmental organizations in the planning and implementation of the above programmes;

(3) to contribute to the evaluation of the above programmes, particularly with regard to their adequacy and effectiveness;

(4) to report periodically to the Health Assembly on the progress of the programmes.

Hbk Res., Vol. II (4th ed.), 7.1.3

(Sixteenth plenary meeting, 22 May 1981 - Committee B, sixth report)

WHA34.31 Liberation struggle in Southern Africa - Assistance to front-line States

The Thirty-fourth World Health Assembly,

Recalling resolutions WHA29.23, WHA30.24, WHA31.52, and WHA32.20;

Referring to resolution AFR/RC30/R14 of the Regional Committee for Africa adopted in conformity with operative paragraph 3(1) of resolution WHA33.17 on the study of the Organization's structures in the light of its functions;

Recalling resolutions WHA33.33 and WHA33.34, and further recalling the relevant resolutions of the United Nations General Assembly and Security Council concerning the liberation movements in Southern Africa recognized by the Organization of African Unity;

Noting the escalation of aggression perpetrated by the racist minority regime of South Africa against the People's Republic of Angola, the People's Republic of Mozambique and the Republic of Zambia;

Considering the effects of the attacks and bombings of the civilian population and the destruction of the health infrastructure in front-line States, coupled with the economic blackmail of those States and Lesotho and Swaziland;

Considering that the persistent refusal of the racist South Africa regime to negotiate with the legitimate representatives of the people of Namibia poses an additional threat to security and welfare of the peoples of the front-line States and Lesotho and Swaziland;

Reaffirming the right of the people of Namibia and South Africa to determine their own health policies and to participate in the global strategy for health for all by the year 2000;

Bearing in mind that the deterioration in the situation in Namibia and South Africa is leading to an increase in the number of refugees in the front-line States, Lesotho and Swaziland;

Bearing in mind that, despite action taken pursuant to resolution WHA33.34 concerning the Republic of Zimbabwe, the health situation in this newly independent country still remains serious;

1. EXPRESSES once again its satisfaction at the concerted efforts made by WHO and other United Nations agencies and the international community and their technical cooperation with the above-mentioned Member States;

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

3. GIVES its full and entire support to the front-line States, Lesotho and Swaziland for the assistance given to refugees from South Africa and Namibia;

4. REQUESTS the Director-General to:

(1) intensify cooperation in the field of health with the front-line States, victims of repeated aggressions by the South African regime, as well as with Lesotho and Swaziland which have also suffered provocations and economic blackmail;

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

(3) continue collaboration with the United Nations agencies and the international community in order to obtain the necessary support in the health sector of national liberation movements recognized by the Organization of African Unity;

(4) accelerate the implementation of the special action programmes for support to Zimbabwe, in collaboration with other United Nations agencies;

(5) submit a detailed report to the Thirty-fifth World Health Assembly of the progress made in the implementation of this resolution.

Hbk Res., Vol. II (4th ed.), 1.2.2.2

(Sixteenth plenary meeting, 22 May 1981 - Committee B, sixth report)

WHA34.32 Special programme of cooperation with the Republic of Equatorial Guinea

The Thirty-fourth World Health Assembly,

Referring to resolution AFR/RC30/R3 of the Regional Committee for Africa;

Taking into account the gravity of the health situation existing in the Republic of Equatorial Guinea;

1. NOTES the creation of a special programme of cooperation with Equatorial Guinea;

2. INVITES Member States, in the spirit of technical cooperation among developing countries and of African solidarity, to give full moral, technical, financial and material support to this programme;

3. REQUESTS the Director-General to take all necessary measures for:

(1) examining, in close collaboration with the Regional Committee for Africa and the Regional Director, the possibilities of financing the action requested by the Republic of Equatorial Guinea;

(2) releasing the funds required for financing the special programme of cooperation with Equatorial Guinea;

(3) seeking extrabudgetary funds for this purpose.

Hbk Res., Vol. II (4th ed.), 1.2.2.2 (Sixteenth plenary meeting, 22 May 1981 - Committee B, sixth report)

WHA34.33 Special programme of cooperation with the Republic of Chad

The Thirty-fourth World Health Assembly,

Referring to resolution AFR/RC30/R19 of the Regional Committee for Africa;

Taking into account the gravity of the health situation existing in the Republic of Chad;

1. NOTES the creation of a special programme of cooperation with Chad;

2. INVITES Member States, in the spirit of technical cooperation among developing countries and of African solidarity, to give full moral, technical, financial and material support to this programme;

3. REQUESTS the Director-General to take all necessary measures for:

(1) examining, in close collaboration with the Regional Committee for Africa and the Regional Director, the possibilities of financing the action requested by the Republic of Chad;

(2) releasing the funds required for financing the special programme of cooperation with Chad;

(3) seeking extrabudgetary funds for this purpose.

Hbk Res., Vol. II (4th ed.), 1.2.2.2 (Sixteenth plenary meeting, 22 May 1981 - Committee B, sixth report)

WHA34.34 Liberation struggle in Southern Africa - Assistance to Namibia

The Thirty-fourth World Health Assembly,

Recalling the provisions of resolutions WHA30.24 and WHA32.21;

Considering the deterioration of the situation in Namibia resulting from the intransigence of the racist regime of South Africa, which refuses to grant early independence to Namibia in accordance with United Nations Security Council resolution 435 (1978);

Taking into account the fact that the so-called "internal settlement" in Namibia constitutes another threat to the security and welfare of the people of Southern Africa;

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

1. THANKS the Director-General for the assistance received in the field of health by the liberation movements in Southern Africa;

2. URGES the Director-General to:

(1) continue and increase, in collaboration with the other bodies of the United Nations system, WHO's assistance in the health sphere to the South West Africa People's Organization (SWAPO), the true representative of the Namibian people;

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

Hbk Res., Vol. II (4th ed.), 1.2.2.2

(Sixteenth plenary meeting, 22 May 1981 - Committee B, sixth report)

WHA34.35 Health assistance to refugees in Africa

The Thirty-fourth World Health Assembly,

Taking note of resolution CM/Res.814 (XXXV) adopted by the Assembly of the Heads of State and Government of the Organization of African Unity at its seventeenth session, held at Freetown, Sierra Leone, from 1 to 4 July 1980, and United Nations General Assembly resolution 35/42 on the International Conference on Assistance to Refugees in Africa;

Deeply concerned about the plight of refugees in Africa and their ever-increasing numbers, so that they now constitute over half the refugee population of the world;

Noting with appreciation that the Secretary-General of the United Nations convened a successful International Conference on Assistance to Refugees in Africa, in Geneva, on 9 and 10 April 1981;

Appreciating the assistance given to refugees in Africa by those who participated in the Conference and by international and voluntary organizations;

Mindful of the essential principle contained in the WHO Constitution, which provides that the health of all peoples is fundamental to the attainment of peace and security;

1. DECIDES to give high priority to the assistance provided to refugees in Africa in the area of competence of WHO;

2. REQUESTS the Director-General:

(1) to continue and intensify his cooperation, within his fields of competence, with the Office of the United Nations High Commissioner for Refugees and other concerned organizations in the implementation and follow-up of the conclusions of the International Conference on Assistance to Refugees in Africa;

(2) to report to the sixty-ninth session of the Executive Board and the Thirty-fifth World Health Assembly on the measures taken by the Organization to assist the African refugees.

Hbk Res., Vol. II (4th ed.), 1.2.2.2

(Sixteenth plenary meeting, 22 May 1981 - Committee B, seventh report)

WHA34.36 Global Strategy for health for all by the year 2000

The Thirty-fourth World Health Assembly,

Recalling WHO's constitutional objective of the attainment by all peoples of the highest possible level of health, the Declaration of Alma-Ata, and resolutions WHA30.43, WHA32.30, and WHA33.24 concerning health for all by the year 2000 and the formulation of strategies for attaining that goal, as well as resolution 34/58 of the United Nations General Assembly concerning health as an integral part of development;

Having reviewed the Strategy submitted to it by the Executive Board in the document entitled "Global Strategy for health for all by the year 2000";[1]

Considering this Strategy to be an invaluable basis for attaining the goal of health for all by the year 2000 through the solemnly agreed, combined efforts of governments, people and WHO;

1. ADOPTS the Global Strategy for health for all by the year 2000;

2. PLEDGES WHO's total commitment to the fulfilment of its part in this solemn agreement for health;

3. DECIDES that the Health Assembly will monitor the progress and evaluate the effectiveness of the Strategy at regular intervals;

4. INVITES Member States:

(1) to enter into this solemn agreement for health of their own volition, to formulate or strengthen, and implement, their strategies for health for all accordingly, and to monitor their progress and evaluate their effectiveness, using appropriate indicators to this end;

(2) to enlist the involvement of people in all walks of life, including individuals, families, communities, all categories of health workers, nongovernmental organizations, and other associations of people concerned;

5. REQUESTS the Executive Board:

(1) to prepare without delay a plan of action for the immediate implementation, monitoring and evaluation of the Strategy, and submit it, in the light of the observations of the regional committees, to the Thirty-fifth World Health Assembly;

[1] Global Strategy for health for all by the year 2000. Geneva, World Health Organization, 1981 ("Health for All" Series, No. 3).

(2) to monitor and evaluate the Strategy at regular intervals;

(3) to formulate the Seventh and subsequent General Programmes of Work as WHO's support to the Strategy;

6. REQUESTS the regional committees:

(1) to review their regional strategies, update them as necessary in the light of the Global Strategy, and monitor and evaluate them at regular intervals;

(2) to review the Executive Board's draft plan of action for implementing the Strategy and submit their comments to the Board in time for it to consider them at its sixty-ninth session in January 1982;

7. REQUESTS the Director-General:

(1) to ensure that the Secretariat at all operational levels provides the necessary support to Member States for the implementation, monitoring and evaluation of the Strategy;

(2) to follow up all aspects of the implementation of the Strategy on behalf of the Organization's governing bodies, and to report annually to the Executive Board on progress made and problems encountered;

(3) to present the Strategy to the United Nations Economic and Social Council and General Assembly in 1981, and report to them subsequently at regular intervals on progress made in implementing it, as well as United Nations General Assembly resolution 34/58.

Hbk Res., Vol. II (4th ed.), 1.1

(Sixteenth plenary meeting, 22 May 1981 - Committee B, seventh report)

WHA34.37 Resources for strategies for health for all by the year 2000

The Thirty-fourth World Health Assembly,

Recalling resolution WHA30.43, which defined the goal of health for all by the year 2000, resolutions WHA32.30 and WHA33.24, which endorsed the Declaration of Alma-Ata and urged Member States to formulate national strategies for attaining health for all through primary health care as part of a comprehensive national health system, and resolution 34/58 of the United Nations General Assembly concerning health as an integral part of development;

Also recalling resolutions WHA27.29, and WHA29.32, which requested the Director-General to strengthen WHO's mechanisms for attracting and coordinating an increased volume of bilateral and multilateral aid for health;

Noting with satisfaction the decision taken by the Executive Board at its sixty-seventh session concerning the establishment of a Health Resources Group;

Aware that some countries have encountered difficulties in developing and implementing their national strategies for health for all, and convinced that these countries urgently require special support to enable them to overcome their difficulties;

1. WELCOMES the efforts being made by Member States to prepare and implement national strategies for health for all through the development of health systems based on primary health care;

2. URGES all Member States to allocate adequate resources for health and, in particular, for primary health care and the supporting levels of the health system;

3. URGES Member States that are in a position to do so to increase substantially their voluntary contributions, whether to WHO or through all other appropriate channels, for activities in developing countries that form part of a well-defined strategy for health for all, and to cooperate with these countries and support them in overcoming the obstacles impeding the development of their strategies for health for all;

4. INVITES the relevant agencies, programmes and funds of the United Nations system, as well as other bodies concerned, to provide financial and other support to developing countries for the implementation of national strategies to achieve health for all by the year 2000;

5. URGES those Member States that, for the implementation of their strategies for health for all, require external sources of funds in addition to their own resources, to identify those needs and report thereon to their regional committees;

6. INVITES the regional committees to review regularly the needs of Member States in the region for external resources in support of well-defined strategies for health for all, and report thereon to the Executive Board;

7. REQUESTS the Executive Board to review regularly the international flow of resources in support of the strategy for health for all, to ensure that such resources are effectively and efficiently used for that purpose, and to report thereon to the Health Assembly;

8. DECIDES that the Health Assembly shall review from time to time the international flow of resources for health, and encourage those Member States that are in a position to do so to ensure an adequate level of transfer;

9. REQUESTS the Director-General:

(1) to support developing countries as required in preparing proposals for external funding for health;

(2) to take appropriate measures for identifying external resource requirements in support of well-defined strategies for health for all, for matching available resources to such needs, for rationalizing the use of such resources, and for mobilizing additional resources if necessary;

(3) to report regularly to the Executive Board on the measures he has taken and the results he has obtained.

Hbk Res., Vol. II (4th ed.), 1.1

(Sixteenth plenary meeting, 22 May 1981 - Committee B, seventh report)

WHA34.38 The role of physicians and other health workers in the preservation and promotion of peace as the most significant factor for the attainment of health for all

The Thirty-fourth World Health Assembly,

Having considered the reports of the Executive Board and of the Director-General on the Global Strategy for the attainment of health for all by the year 2000[1] and the contribution of health to the socioeconomic development of countries,[2] particularly developing countries, as well as to the preservation and promotion of peace as the most significant factor for the protection of people's life and health;

[1] See Global Strategy for health for all by the year 2000. Geneva, World Health Organization, 1981 ("Health for All" Series, No. 3).

[2] Document A34/6.

Bearing in mind the provisions of the WHO Constitution stating that the attainment of the highest possible standard of health of peoples, on the basis of the fullest cooperation of individuals and States, is one of the fundamental factors for peace and security, and also resolution 34/58 of the United Nations General Assembly stating that peace and security, in their turn, are important for the preservation and improvement of the health of all people, and that cooperation among nations on vital health issues can contribute importantly to peace;

Recalling the provision of the Alma-Ata Declaration emphasizing that an "acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts";

Recalling resolutions WHA13.56, WHA13.67, WHA15.51, WHA17.45, WHA20.54, WHA22.58, WHA23.53, WHA32.24, WHA32.30, WHA33.24 and others on the role of the physician in the preservation and promotion of peace, the protection of mankind against nuclear radiation, the reduction of military expenditures and the allocation of the resources thus released to socioeconomic development and also to public health, especially in developing countries;

Considering the present aggravation of the international situation and the growing danger of thermonuclear conflict, whose unleashing in any form and on any scale will inevitably lead to irreversible destruction of the environment and the death of hundreds of millions of people, and also to grave consequences for the life and health of the population of all countries of the world without exception and of future generations, thus undermining the efforts of the States and WHO to achieve health for all by the year 2000;

Noting further the growing concern of physicians and other health workers in many countries at the mounting danger of thermonuclear war as the most serious threat to the life and health of all populations and their desire to prevent thermonuclear disaster, which is an indication of their increased awareness of their moral, professional and social duty and responsibility to safeguard life, to improve human health, and to use all means and resources for attaining health for all;

1. REITERATES most strongly its appeal to Member States to multiply their efforts to consolidate peace in the world, reinforce détente and achieve disarmament so as to create conditions for the release of resources for the development of public health in the world;

2. REQUESTS the Director-General:

(1) to expedite and intensify the study of the contribution that WHO, as a United Nations specialized agency, could and should make to economic and social development and to facilitate the implementation of the United Nations resolutions on strengthening peace, détente and disarmament and preventing thermonuclear conflict, creating for this purpose an international committee composed of eminent experts in medical science and public health;

(2) to continue collaboration with the Secretary-General of the United Nations and with other governmental and nongovernmental organizations, to the extent required, in establishing a broad and authoritative international committee of scientists and experts for comprehensive study and elucidation of the threat of thermonuclear war and its potentially baneful consequences for the life and health of peoples of the world.

Hbk Res., Vol. II (4th ed.), 1.1

(Sixteenth plenary meeting, 22 May 1981 - Committee B, seventh report)

WHA34.39 Material war remnants

The Thirty-fourth World Health Assembly,

Recalling the principles contained in the preamble of the Constitution of WHO that "health is a state of complete physical, mental and social well-being", that "the health of all peoples is fundamental to the attainment of peace and security", and that "the achievement of any State in the promotion and protection of health is of value to all";

Noting that material World War remnants, especially mines, are still present in some countries;

Deeply concerned by the resulting loss of life and the mutilation and disfiguration of civilians, and the other dramatic effects on agriculture, transportation, housing, oil and mineral resources, development planning, and development itself;

Recalling WHO's function to promote the prevention of accidental injuries and, in general, to take all necessary action to attain its objective;

Recalling that this year 1981 has been declared by the United Nations as the International Year of Disabled Persons, and that the role of WHO in preventing disabilities due to such injuries is of paramount significance;

Recalling resolution 34/58 of the United Nations General Assembly and resolutions WHA32.24 and WHA33.24 concerning the contribution of health to socioeconomic development and peace;

Emphasizing the urgency not only of preventing war but also of alleviating the dramatic health conditions resulting therefrom;

Recalling United Nations General Assembly resolution 3435 (XXX) of 9 December 1975 calling upon the Member States responsible to carry out their obligations by removing those remnants and redressing the damage caused by their existence;

Bearing in mind that this matter will be further considered by the United Nations General Assembly at its thirty-sixth session;

1. REQUESTS States to clear the material war remnants, especially mines;

2. REQUESTS the States that laid these mines to cooperate in this process as far as possible by providing appropriate assistance and information regarding the types and exact location of the mines and other explosives, and regarding other relevant questions;

3. REQUESTS the Director-General to report to the Thirty-sixth World Health Assembly on the situation related to health and the progress achieved.

Hbk Res., Vol. II (4th ed.), 7.1; 7.1.3

(Sixteenth plenary meeting, 22 May 1981 - Committee B, seventh report)

DECISIONS

(1) Composition of the Committee on Credentials

The Thirty-fourth World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Member States: Argentina; Bahrain; Belgium; Bulgaria; Denmark; Jamaica; Kenya; New Zealand; Nigeria; Senegal; Sudan; and Thailand.

(First plenary meeting, 4 May 1981)

(2) Composition of the Committee on Nominations

The Thirty-fourth World Health Assembly elected a committee on Nominations consisting of delegates of the following 24 Member States: Chile; China; Ecuador; France; Guatemala; Hungary; India; Ivory Coast; Lesotho; Libyan Arab Jamahiriya; Mexico; Morocco; Oman; Singapore; Sri Lanka; Trinidad and Tobago; Tunisia; Union of Soviet Socialist Republics; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Cameroon; United Republic of Tanzania; Zaire; and Zambia.

(First plenary meeting, 4 May 1981)

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

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

President: Dr Méropi Violaki-Paraskeva (Greece)

Vice-Presidents:

Mr M. C. Jallow (Gambia), Mr M. M. Hussain (Maldives),
Dr J. Andonie Fernández (Honduras), Dr Qian Xinzhong (China),
Dr C. Rifai (Syrian Arab Republic)

(Second plenary meeting, 5 May 1981)

(4) Election of officers of the main committees

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

COMMITTEE A: Chairman, Dr E. P. F. Braga (Brazil)

COMMITTEE B: Chairman, Dr Z. M. Dlamini (Swaziland)

(Second plenary meeting, 5 May 1981)

The main committees subsequently elected the following officers:

COMMITTEE A: Vice-Chairmen, Dr J. Rogowski (Poland) and Dr A. A. K. Al-Ghassany (Oman); Rapporteur, Dr J. M. Kasonde (Zambia)

COMMITTEE B: Vice-Chairmen, Dr L. Sánchez-Harguindey (Spain)[1] and Dr A. Hassoun (Iraq); Rapporteur, Dr Deanna Ashley (Jamaica)

(First meetings of Committees A and B, 7 May 1981)

(5) Establishment of the General Committee

The Thirty-fourth 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: Chile; Costa Rica; France; German Democratic Republic; Kuwait; Libyan Arab Jamahiriya; Malaysia; Mongolia; Nigeria; Senegal; Tunisia; Union of Soviet Socialist Republics; United Kingdom of Great Britain and Northern Ireland; United Republic of Cameroon; United States of America; and Zimbabwe.

(Second plenary meeting, 5 May 1981)

(6) Adoption of the agenda

The Thirty-fourth World Health Assembly adopted the provisional agenda prepared by the Executive Board at its sixty-seventh session with the deletion of three items.

(Third plenary meeting, 5 May 1981)

(7) Verification of credentials

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

Members

Afghanistan; Albania; Algeria; Angola; Argentina; Australia; Austria; Bahamas; Bahrain; Bangladesh; Belgium; Benin; Bolivia; Botswana; Brazil; Bulgaria; Burma; Burundi; Canada; Cape Verde; Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Costa Rica; Cuba; Cyprus; Czechoslovakia; Democratic Kampuchea; Democratic People's Republic of Korea; Democratic Yemen; Denmark; Djibouti; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Ethiopia; Fiji; Finland; France; Gabon; Gambia; German Democratic Republic; Germany, Federal Republic of; Ghana; Greece; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran; Iraq; Ireland; Israel; Italy; Ivory Coast; Jamaica; Japan; Jordan; Kenya; Kuwait; Lao People's Democratic Republic; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Mauritania; Mauritius; Mexico; Monaco; Mongolia; Morocco; Mozambique; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Romania; Rwanda; Samoa; 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, tenth and fourteenth plenary meetings, 6, 13 and 20 May 1981)

[1] Dr Sánchez-Harguindey being obliged to return to his country, Dr M. de la Mata (Spain) was elected Vice-Chairman in his stead at the Committee's fourth meeting.

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

The Thirty-fourth 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: Bulgaria; Guinea-Bissau; Japan; Maldives; Mozambique; Sao Tome and Principe; Seychelles; Spain; United Arab Emirates; and United States of America.

(Tenth plenary meeting, 13 May 1981)

(9) Report of the Director-General on the work of WHO in 1980

The Thirty-fourth World Health Assembly, after reviewing the Director-General's report on the work of the Organization in 1980,[2] noted with satisfaction the manner in which the Organization's programme for this year had been implemented.

(Eleventh plenary meeting, 14 May 1981)

(10) Reports of the Executive Board on its sixty-sixth and sixty-seventh sessions

The Thirty-fourth World Health Assembly, after reviewing the Executive Board's reports on its sixty-sixth[3] and sixty-seventh[4] sessions,[5] 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.

(Fourteenth plenary meeting, 20 May 1981)

(11) Annual report of the United Nations Joint Staff Pension Board for 1979

The Thirty-fourth 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 1979[6] and as reported by the Director-General.

(Fifteenth plenary meeting, 21 May 1981)

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

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

(Fifteenth plenary meeting, 21 May 1981)

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

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

(Sixteenth plenary meeting, 22 May 1981)

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[1] For report of the General Committee, see document WHA34/1981/REC/2.

[2] See Annex 4.

[3] Document EB66/1980/REC/1.

[4] Documents EB67/1981/REC/1, EB67/1981/REC/2 and EB67/1981/REC/3.

[5] See also document A34/2

[6] Document A34/23.

ANNEXES

ANNEX 1

REPORT ON CASUAL INCOME AND BUDGETARY RATE OF EXCHANGE BETWEEN THE US DOLLAR AND THE SWISS FRANC FOR 1982-1983[1]

/A34/11 - 23 April 1981/

Report by the Director-General

Casual income available as of 31 December 1980

1. For the information of the Health Assembly, Appendix 1 shows the amounts of casual income available at year-end during the period 1977-1980, and the amounts appropriated for the regular budget, supplementary budget, or other purposes.

2. It will be noted that the amount of casual income available at 31 December 1980, as reflected in Appendix 1 to this report and on page 15 of document A34/9 (Interim financial report for the year 1980), is US$ 26 461 296, as compared with the tentative estimate of US$ 23 036 749 reported to the sixty-seventh session of the Executive Board in January 1981. The difference is due largely to increased interest earned on deposits in banks pending disbursements and to higher than anticipated savings on the liquidation of prior years' obligations. The details of casual income earned and utilized during the years 1977-1980 are shown on page 16 of document A34/9.

Proposed appropriations in 1981 of available casual income

3. On the recommendation of the Director-General, the Executive Board at its sixty-seventh session (January 1981) recommended to the Health Assembly the appropriation of casual income as follows:

(i) an amount of US$ 2 044 000 to the Real Estate Fund (resolution EB67.R20);[2] and

(ii) an amount of US$ 12 000 000 to help finance the proposed 1982-1983 budget (resolution EB67.R6).[3]

The unappropriated balance of casual income available after appropriation of these amounts would be as follows:

	US$	US$
Casual income available at 31 December 1980 (see paragraph 2 above)		26 461 296
Less above-mentioned amounts appropriated for:		
(i) Real Estate Fund	2 044 000	
(ii) 1982-1983 programme budget	12 000 000	14 044 000
Unappropriated balance		12 417 296

[1] See resolution WHA34.5.

[2] Document EB67/1981/REC/1, p. 21.

[3] Document EB67/1981/REC/1. p. 4.

4. In resolution WHA32.4 the Thirty-second World Health Assembly (May 1979) authorized the Director-General "to charge against available casual income the net additional costs to the Organization under the regular programme budget resulting from differences between the WHO budgetary rate of exchange and the United Nations/WHO accounting rates of exchange with respect to the US dollar/Swiss franc relationship prevailing during this financial period, provided that such charges against casual income shall not exceed US$ 15 000 000 in 1980-1981". In the same resolution, the Director-General was requested "to transfer to casual income the net savings under the regular programme budget resulting from differences between the WHO budgetary rate of exchange and the United Nations/WHO accounting rates of exchange with respect to the US dollar/Swiss franc relationship prevailing during this financial period, provided that, having regard to inflationary trends and other factors which may affect the implementation of the regular programme budget, such transfers to casual income need not exceed US$ 15 000 000 in 1980-1981". As such net additional costs or net savings under the regular programme budget for 1980-1981 cannot be determined until the end of the financial period, the Director-General was further requested by resolution WHA32.4 to report the resulting charges or transfers in the financial report for the financial period 1980-1981, which will be submitted to the Thirty-fifth World Health Assembly in May 1982.

5. As the United Nations/WHO accounting rates of exchange in respect of the US dollar/Swiss franc relationship during the first 16 months of the current financial period (i.e., from January 1980 to April 1981) have been consistently higher than the WHO budgetary rate of exchange for 1980-1981 of 1.55 Swiss francs per US dollar, the Organization has so far not incurred any of the additional costs referred to in resolution WHA32.4. Since the time of the sixty-seventh session of the Executive Board in January 1981 the exchange value of the dollar has continued to rise in relation to the Swiss franc, and the average of the accounting rates of exchange during the first 16 months of the financial period 1980-1981 has been 1.72 Swiss francs per US dollar. The Director-General therefore believes that, although currency exchange rates continue to be unstable and unpredictable, there is now very little, if any, risk that the average of the accounting rates of exchange during the whole financial period 1980-1981 will turn out to be lower than the budgetary rate of 1.55 Swiss francs per US dollar used for that biennium. It is therefore extremely unlikely that recourse will still have to be had during the current financial period to the casual income facility provided by resolution WHA32.4. In fact, it now seems likely that, as a result of the average of the accounting rates of exchange during the whole financial period being higher than the budgetary rate, there will be substantial savings under the regular budget for 1980-1981 pursuant to resolution WHA32.4. These savings, in the form of a budget surplus at the end of 1981, will become cash in the casual income account to the extent, and at the time, that the collection of assessed contributions for 1980-1981 exceeds the obligations incurred during this financial period.

6. In these circumstances the Director-General believes that it is no longer necessary to maintain in 1981 an unappropriated balance of casual income (i.e., US$ 12 417 296, as indicated in paragraph 3 above) to safeguard the Organization's programme for the remainder of the current biennium against a possible adverse impact of unforeseen exchange rate movements. This would make it possible to use a larger amount of casual income to help finance the regular budget for 1982-1983 than was proposed to the Executive Board in January 1981, thus further reducing assessments on Members for the forthcoming financial period. The Director-General therefore proposes that an additional amount of US$ 12 400 000 of available casual income (over and above the US$ 12 000 000 recommended by the Executive Board at its sixty-seventh session) be appropriated for the financing of the regular budget for 1982-1983. As will be seen from paragraph 3 above, this will bring the total amount of casual income appropriated for this purpose to US$ 24 400 000, or virtually all the casual income available after the requirements of the Real Estate Fund have been met.

Budgetary rate of exchange between the US dollar and the Swiss franc for 1982-1983

7. As indicated on page 365 of the proposed programme budget for 1982-1983 (document PB/82-83), the rate of exchange used in preparing the proposed 1982-1983 budget for expenditure to be incurred in Swiss francs was 1.63 Swiss francs per US dollar, which corresponded to the United Nations/WHO accounting rate of exchange for October 1980, when the programme budget proposals were being finalized.

8. Since October 1980 the United Nations/WHO accounting rates of exchange between the US dollar and the Swiss franc have been consistently higher than the October 1980 rate of 1.63 Swiss francs per US dollar:

		Swiss francs per US dollar
1980	November	1.71
"	December	1.71
1981	January	1.76
"	February	1.92
"	March	1.96
"	April	1.91

While the recent trend of these exchange rates may justify a certain degree of optimism as to the rates which may prevail in 1982 and 1983, it should be recalled that, as noted above, currency exchange rates continue to be highly volatile and unpredictable. In 1980, for example, the monthly United Nations/WHO accounting rates of exchange fluctuated between 1.85 Swiss francs and 1.60 Swiss francs per US dollar, the average rate for the year being 1.67 Swiss francs per US dollar. Moreover, in recent years the value of the US dollar in relation to the Swiss franc has several times stabilized and even increased substantially for periods as long as six months to a year, only to be followed by equally long periods during which it fell quite significantly.

9. While it would therefore not be prudent to adjust the budgetary rate of exchange for 1982-1983 to the level of the latest accounting rate of exchange, the Director-General feels that the difference between the budgetary rate of 1.63 Swiss francs per US dollar and the recently attained exchange value of the US dollar in relation to the Swiss franc may appear to be so substantial that some adjustment to the former might be considered appropriate. Such an upward adjustment of the budgetary rate of exchange would probably be welcomed by Members, since its budgetary impact would be to reduce the level of the proposed effective working budget, and thus assessed contributions of Members, without affecting the volume or quality of the proposed programme.

10. The Director-General therefore proposes that the budgetary rate of exchange for 1982-1983 be adjusted to the average which the accounting rates of exchange for the whole financial period 1980-1981 would reach if the average of the rates for the remaining eight months of the current biennium were to be at the level of the current rate, i.e. 1.91 Swiss francs per US dollar. As indicated in paragraph 5 above, the average of the accounting rates of exchange during the first 16 months of the financial period 1980-1981 has been 1.72 Swiss francs per US dollar; if the average of the accounting rates of exchange during the remaining eight months of the financial period were to be 1.91 Swiss francs per US dollar, the average of the accounting rates of exchange for the whole financial period 1980-1981 would become 1.78 Swiss francs per US dollar. The budgetary rate of exchange for 1982-1983 would therefore be adjusted from 1.63 Swiss francs per US dollar to 1.78 Swiss francs per US dollar. Although it is impossible to foresee whether a revised budgetary rate of 1.78 Swiss francs per US dollar will be closer to the actual accounting rates of exchange prevailing in 1982-1983 than the original budgetary rate of 1.63 Swiss francs per US dollar, such an adjustment would not, in the present circumstances, appear to be imprudent if the Health Assembly would be prepared to authorize the Director-General to use sufficient available casual income to protect the programme budget for 1982-1983 against possible adverse effects of currency fluctuations.

Proposed use of casual income to meet possible adverse effects of currency fluctuations on the programme budget for 1982-1983

11. In resolution EB67.R5[1] the Executive Board recommended to the Thirty-fourth World Health Assembly that, as was the case in 1979 and 1980-1981, the Director-General again be authorized in 1982-1983 to charge against available casual income the net additional costs under the regular programme budget which may result from differences between the WHO budgetary rate of exchange and the United Nations/WHO accounting rates of exchange prevailing during the financial period 1982-1983, up to a maximum of US$ 15 000 000. In the same resolution the

[1] Document EB67/1981/REC/1, p. 2.

Executive Board recommended that the Director-General be requested to transfer to casual income any net savings under the regular programme budget resulting from those differences, provided that, having regard to inflationary trends and other factors which might affect the implementation of the regular programme budget, such transfers to casual income need not exceed US$ 15 000 000. Such transfers or charges would be reported in the financial report of the Organization for the 1982-1983 biennium.

12. On the basis of a budgetary rate of exchange of 1.63 Swiss francs per US dollar for 1982-1983 it was envisaged that adoption of the recommendations contained in resolution EB67.R5 would permit the Director-General to cope with an average accounting rate of exchange during 1982-1983 as low as 1.46 Swiss francs per US dollar, without the need for recourse to programme reductions, a supplementary budget or other measures. However, if the Thirty-fourth World Health Assembly should decide to adjust the budgetary rate of exchange to 1.78 Swiss francs per US dollar, the proposed casual income facility of US$ 15 000 000 would protect the Organization's programme only if the average accounting rate of exchange during 1982-1983 would be at least 1.58 Swiss francs per US dollar. In view of the continuing volatility and unpredictability of currency exchange rates, the Director-General believes that it would be advisable to increase the maximum amount of the casual income which he would be permitted to use to protect the Organization's programme to US$ 20 000 000, thus enabling him to cope with an average accounting rate of exchange during 1982-1983 as low as 1.52 Swiss francs per US dollar. If the average accounting rate of exchange should be higher than 1.52 Swiss francs but lower than 1.78 Swiss francs per US dollar, casual income in an amount smaller than the maximum of US$ 20 000 000 would be necessary. Similarly, if the average accounting rate of exchange should be higher than the budgetary rate of 1.78 Swiss francs per US dollar, the Director-General would credit to casual income, subject to a maximum of US$ 20 000 000, any budget surplus arising as a result of such favourable monthly accounting rates of exchange. As in the past, the use of casual income for the reasons proposed would not obviate the need for economies in operations at headquarters, in particular if the average accounting rate of exchange for 1982-1983 were to be lower than 1.52 Swiss francs per US dollar, if the amount of available casual income during that period were less than US$ 20 000 000, or if actual cost increases due to inflation were to exceed those estimated during the preparation of the programme budget proposals.

13. The Director-General expects that sufficient casual income will become available to meet the requirements (i.e., up to a maximum of US$ 20 000 000, as proposed) which may arise from possible adverse effects of currency fluctuations on the programme budget for 1982-1983 from (i) interest income to be earned on bank deposits in 1981 and, if necessary, in 1982, and (ii) the expected budget surplus for 1980-1981, referred to in paragraph 5 above.

Budgetary impact of proposals

14. As has already been indicated, both the appropriation of an additional US$ 12 400 000 of casual income to help finance the regular budget for 1982-1983 and the upward adjustment of the budgetary exchange rate for 1982-1983 from 1.63 Swiss francs to 1.78 Swiss francs per US dollar would have the effect of further reducing substantially the assessed contributions of Members for the financial period 1982-1983. The proposed upward adjustment of the budgetary exchange rate would also have the effect of reducing the level of the proposed effective working budget for 1982-1983 from US$ 484 300 000 to US$ 473 629 400.

15. It will be recalled that the effective working budget of US$ 484 300 000 for 1982-1983 recommended by the Executive Board in resolution EB67.R6[1] represented a total increase of 13.34% over the effective working budget for 1980-1981, and would entail an increase of 10.60% in assessments for the effective working budget for 1982-1983 over the assessments for the effective working budget for 1980-1981. The effect of adjusting the budgetary rate of exchange from 1.63 Swiss francs per US dollar to 1.78 Swiss francs per US dollar would be to reduce the total increase in the effective working budget for 1982-1983 over that for 1980-1981 from 13.34% to 10.84%, and the combined effect of the adjustment of the budgetary rate of exchange and the appropriation of an additional US$ 12 400 000 of casual income to help finance the regular budget for 1982-1983 would be to reduce the increase in the assessments for the effective working budget from 10.60% to 5.14%.

[1] Document EB67/1981/REC/1, p.4.

16. Appendix 2 is a revision of the table on page 31 of the 1982-1983 proposed programme budget (document PB/82-83) in the light of the above proposals. Similarly, Appendix 3 is a revision of the scale of assessments for 1982-1983 that appears on pages 32 to 37 of the same document, reflecting those proposals.

Conclusion

17. If the Thirty-fourth World Health Assembly should agree to the proposals made above, it would be necessary to revise the draft Appropriation Resolution for the financial period 1982-1983 proposed by the Executive Board in resolution EB67.R6[1] in order to reflect the change in the proposed effective working budget for 1982-1983 which would result from using a budgetary rate of exchange of 1.78 Swiss francs per US dollar. The revised Appropriation Resolution would also have to reflect the increase - from US$ 12 000 000 to US$ 24 400 000 - in the amount of casual income to be appropriated to help finance the regular budget. Moreover, it would also be necessary to change the amounts shown in paragraphs 1 and 2 of the draft resolution recommended by the Executive Board in resolution EB67.R5[2] from US$ 15 000 000 to US$ 20 000 000 in order to reflect the proposed change in the maximum amount of the casual income facility for 1982-1983.

[1] Document EB67/1981/REC/1, p. 4.

[2] Document EB67/1981/REC/1, p. 2.

Appendix 1

CASUAL INCOME 1977-1980

(expressed in US dollars)

Year	Balance 1 January	Appropriated for					Unappropriated balance	Casual income earned during the year	Available balance at 31 December
		Regular budget	Year	Supplementary budget	Year	Other purposes[a]			
1977	6 810 600	3 000 000	1978	-	-	28 335	3 782 265	6 503 515	10 285 780
1978	10 285 780	610 000	1979	6 600 000	1978	2 016 320	1 059 460	8 275 675	9 335 135
1979	9 335 135	-	-	-	-	10 983 090	(1 647 955)	12 809 979	11 162 024
1980	11 162 024	-	-	-	-	1 333 275	9 828 749	16 632 547	26 461 296

[a] Details of funds appropriated for other purposes:

	Real Estate Fund	Adjustment and exemption from payment of assessments on Members	Executive Board Special Fund	Use of casual income to reduce adverse effects of currency fluctuations on the programme budget
1977	-	28 335	-	-
1978	-	16 320	-	2 000 000
1979	-	18 380	-	10 964 710
1980	1 290 000	43 275	-	-

Appendix 2

TOTAL REGULAR BUDGET, ASSESSMENTS AND EFFECTIVE WORKING BUDGET
(Revised)

	1978-1979	1980-1981	1982-1983
	US $	US $	US $
1. Total budget	402 063 510	477 135 300	527 770 800[a]
2. Deduction (as per item 8 below)	15 410 000	4 400 000	29 000 000
3. Assessments on Members	386 653 510	472 735 300	498 770 800[a]
4. Less:			
Credits from Tax Equalization Fund	31 670 450	32 625 850	35 096 000
5. Contributions from Members[b]	354 983 060	440 109 450	463 674 800
6. Less:			
(i) Estimated tax reimbursements payable from the Tax Equalization Fund	8 011 250	7 374 150	8 904 000
(ii) Amount of Undistributed Reserve[c]	8 051 810	9 845 300	10 141 400[a]
7. Contributions for effective working budget	338 920 000	422 890 000	444 629 400
8. Add:			
(i) Reimbursement of programme support costs by the United Nations Development Programme in the estimated amount of	5 200 000	4 400 000	4 600 000
(ii) Casual income	10 210 000	-	24 400 000
9. Total effective working budget	354 330 000	427 290 000	473 629 400

[a] These amounts are subject to such adjustments as may be decided by the Thirty-fourth World Health Assembly.

[b] See Scales of Assessments.

[c] The Undistributed Reserve equals the amounts of the net assessments on inactive Members (the Byelorussian SSR and the Ukrainian SSR) and on South Africa.

Appendix 3

SCALE OF ASSESSMENTS FOR 1982-1983

(Revised)

Members and Associate Members	Percentage	Gross assessments	Credit from Tax Equalization Fund	Net contributions for 1982-1983	Payable in 1982	Payable in 1983
	%	US $	US $	US $	US $	US $
Afghanistan	0.01	49 880	4 400	45 480	22 740	22 740
Albania	0.01	49 880	4 400	45 480	22 740	22 740
Algeria	0.12	598 520	52 800	545 720	272 860	272 860
Angola	0.01	49 880	4 400	45 480	22 740	22 740
Argentina	0.77	3 840 530	338 800	3 501 730	1 750 865	1 750 865
Australia	1.80	8 977 870	792 000	8 185 870	4 092 935	4 092 935
Austria	0.70	3 491 390	308 000	3 183 390	1 591 695	1 591 695
Bahamas	0.01	49 880	4 400	45 480	22 740	22 740
Bahrain	0.01	49 880	4 400	45 480	22 740	22 740
Bangladesh	0.04	199 510	17 600	181 910	90 955	90 955
Barbados	0.01	49 880	4 400	45 480	22 740	22 740
Belgium	1.20	5 985 250	528 000	5 457 250	2 728 625	2 728 625
Benin	0.01	49 880	4 400	45 480	22 740	22 740
Bolivia	0.01	49 880	4 400	45 480	22 740	22 740
Botswana	0.01	49 880	4 400	45 480	22 740	22 740
Brazil	1.25	6 234 630	550 000	5 684 630	2 842 315	2 842 315
Bulgaria	0.16	798 030	70 400	727 630	363 815	363 815
Burma	0.01	49 880	4 400	45 480	22 740	22 740
Burundi	0.01	49 880	4 400	45 480	22 740	22 740
Byelorussian Soviet Socialist Republic	0.38	1 895 340	167 200	1 728 140	864 070	864 070
Canada	3.22	16 060 420	1 381 800	14 678 620	7 339 310	7 339 310
Cape Verde	0.01	49 880	4 400	45 480	22 740	22 740
Central African Republic	0.01	49 880	4 400	45 480	22 740	22 740
Chad	0.01	49 880	4 400	45 480	22 740	22 740
Chile	0.07	349 140	30 800	318 340	159 170	159 170
China	1.59	7 930 450	699 600	7 230 850	3 615 425	3 615 425
Colombia	0.11	548 650	48 400	500 250	250 125	250 125
Comoros	0.01	49 880	4 400	45 480	22 740	22 740
Congo	0.01	49 880	(61 600)	111 480	55 740	55 740
Costa Rica	0.02	99 750	8 800	90 950	45 475	45 475
Cuba	0.11	548 650	48 400	500 250	250 125	250 125
Cyprus	0.01	49 880	4 400	45 480	22 740	22 740
Czechoslovakia	0.82	4 089 920	360 800	3 729 120	1 864 560	1 864 560
Democratic Kampuchea	0.01	49 880	4 400	45 480	22 740	22 740
Democratic People's Republic of Korea	0.05	249 380	22 000	227 380	113 690	113 690
Democratic Yemen	0.01	49 880	(8 600)	58 480	29 240	29 240
Denmark	0.73	3 641 020	321 200	3 319 820	1 659 910	1 659 910
Djibouti	0.01	49 880	4 400	45 480	22 740	22 740
Dominican Republic	0.03	149 630	13 200	136 430	68 215	68 215
Ecuador	0.02	99 750	8 800	90 950	45 475	45 475
Egypt	0.07	349 140	30 800	318 340	159 170	159 170
El Salvador	0.01	49 880	4 400	45 480	22 740	22 740
Equatorial Guinea	0.01	49 880	4 400	45 480	22 740	22 740
Ethiopia	0.01	49 880	4 400	45 480	22 740	22 740
Fiji	0.01	49 880	4 400	45 480	22 740	22 740
Finland	0.47	2 344 220	206 800	2 137 420	1 068 710	1 068 710
France	6.15	30 674 400	1 914 000	28 760 400	14 380 200	14 380 200
Gabon	0.02	99 750	8 800	90 950	45 475	45 475
Gambia	0.01	49 880	4 400	45 480	22 740	22 740
German Democratic Republic	1.37	6 833 160	602 800	6 230 360	3 115 180	3 115 180
Germany, Federal Republic of	8.17	40 749 570	3 594 800	37 154 770	18 577 385	18 577 385
Ghana	0.03	149 630	13 200	136 430	68 215	68 215
Greece	0.34	1 695 820	149 600	1 546 220	773 110	773 110
Grenada	0.01	49 880	4 400	45 480	22 740	22 740
Guatemala	0.02	99 750	8 800	90 950	45 475	45 475
Guinea	0.01	49 880	4 400	45 480	22 740	22 740
Guinea-Bissau	0.01	49 880	4 400	45 480	22 740	22 740
Guyana	0.01	49 880	4 400	45 480	22 740	22 740
Haiti	0.01	49 880	4 400	45 480	22 740	22 740
Honduras	0.01	49 880	4 400	45 480	22 740	22 740
Hungary	0.32	1 596 060	140 800	1 455 260	727 630	727 630
Iceland	0.03	149 630	13 200	136 430	68 215	68 215
India	0.59	2 942 750	259 600	2 683 150	1 341 575	1 341 575
Indonesia	0.16	798 030	70 400	727 630	363 815	363 815
Iran	0.64	3 192 130	281 600	2 910 530	1 455 265	1 455 265
Iraq	0.12	598 520	52 800	545 720	272 860	272 860
Ireland	0.16	798 030	70 400	727 630	363 815	363 815
Israel	0.24	1 197 050	105 600	1 091 450	545 725	545 725
Italy	3.39	16 908 330	1 491 600	15 416 730	7 708 365	7 708 365
Ivory Coast	0.03	149 630	13 200	136 430	68 215	68 215
Jamaica	0.02	99 750	8 800	90 950	45 475	45 475
Japan	9.42	46 984 210	4 144 800	42 839 410	21 419 705	21 419 705
Jordan	0.01	49 880	4 400	45 480	22 740	22 740
Kenya	0.01	49 880	4 400	45 480	22 740	22 740
Kuwait	0.20	997 540	88 000	909 540	454 770	454 770
Lao People's Democratic Republic	0.01	49 880	4 400	45 480	22 740	22 740
Lebanon	0.03	149 630	13 200	136 430	68 215	68 215
Lesotho	0.01	49 880	4 400	45 480	22 740	22 740
Liberia	0.01	49 880	4 400	45 480	22 740	22 740
Libyan Arab Jamahiriya	0.22	1 097 290	96 800	1 000 490	500 245	500 245
Luxembourg	0.05	249 380	22 000	227 380	113 690	113 690
Madagascar	0.01	49 880	4 400	45 480	22 740	22 740
Malawi	0.01	49 880	4 400	45 480	22 740	22 740
Malaysia	0.09	448 890	39 600	409 290	204 645	204 645
Maldives	0.01	49 880	4 400	45 480	22 740	22 740
Mali	0.01	49 880	4 400	45 480	22 740	22 740
Malta	0.01	49 880	4 400	45 480	22 740	22 740
Mauritania	0.01	49 880	4 400	45 480	22 740	22 740
Mauritius	0.01	49 880	4 400	45 480	22 740	22 740
Mexico	0.75	3 740 780	330 000	3 410 780	1 705 390	1 705 390
Monaco	0.01	49 880	4 400	45 480	22 740	22 740
Mongolia	0.01	49 880	4 400	45 480	22 740	22 740
Morocco	0.05	249 380	22 000	227 380	113 690	113 690

SCALE OF ASSESSMENTS FOR 1982-1983 (continued)

Members and Associate Members	Percentage	Gross assessments	Credit from Tax Equalization Fund	Net contributions for 1982-1983	Payable in 1982	Payable in 1983
	%	US $	US $	US $	US $	US $
Mozambique	0.01	49 880	4 400	45 480	22 740	22 740
Namibia[a]	0.01	49 880	4 400	45 480	22 740	22 740
Nepal	0.01	49 880	4 400	45 480	22 740	22 740
Netherlands	1.60	7 980 330	704 000	7 276 330	3 638 165	3 638 165
New Zealand	0.26	1 296 800	114 400	1 182 400	591 200	591 200
Nicaragua	0.01	49 880	4 400	45 480	22 740	22 740
Niger	0.01	49 880	4 400	45 480	22 740	22 740
Nigeria	0.16	798 030	70 400	727 630	363 815	363 815
Norway	0.49	2 443 970	215 600	2 228 370	1 114 185	1 114 185
Oman	0.01	49 880	4 400	45 480	22 740	22 740
Pakistan	0.07	349 140	30 800	318 340	159 170	159 170
Panama	0.02	99 750	8 800	90 950	45 475	45 475
Papua New Guinea	0.01	49 880	4 400	45 480	22 740	22 740
Paraguay	0.01	49 880	4 400	45 480	22 740	22 740
Peru	0.06	299 260	26 400	272 860	136 430	136 430
Philippines	0.10	498 770	44 000	454 770	227 385	227 385
Poland	1.22	6 085 000	536 800	5 548 200	2 774 100	2 774 100
Portugal	0.19	947 660	83 600	864 060	432 030	432 030
Qatar	0.03	149 630	13 200	136 430	68 215	68 215
Republic of Korea	0.15	748 150	66 000	682 150	341 075	341 075
Romania	0.20	997 540	88 000	909 540	454 770	454 770
Rwanda	0.01	49 880	4 400	45 480	22 740	22 740
Samoa	0.01	49 880	4 400	45 480	22 740	22 740
San Marino	0.01	49 880	4 400	45 480	22 740	22 740
Sao Tome and Principe	0.01	49 880	4 400	45 480	22 740	22 740
Saudi Arabia	0.57	2 842 990	250 800	2 592 190	1 296 095	1 296 095
Senegal	0.01	49 880	4 400	45 480	22 740	22 740
Seychelles	0.01	49 880	4 400	45 480	22 740	22 740
Sierra Leone	0.01	49 880	4 400	45 480	22 740	22 740
Singapore	0.08	399 010	35 200	363 810	181 905	181 905
Somalia	0.01	49 880	4 400	45 480	22 740	22 740
South Africa	0.41	2 044 960	180 400	1 864 560	932 280	932 280
Spain	1.67	8 329 470	734 800	7 594 670	3 797 335	3 797 335
Sri Lanka	0.02	99 750	8 800	90 950	45 475	45 475
Sudan	0.01	49 880	4 400	45 480	22 740	22 740
Suriname	0.01	49 880	4 400	45 480	22 740	22 740
Swaziland	0.01	49 880	4 400	45 480	22 740	22 740
Sweden	1.29	6 434 140	567 600	5 866 540	2 933 270	2 933 270
Switzerland	1.03	5 137 340	453 200	4 684 140	2 342 070	2 342 070
Syrian Arab Republic	0.03	149 630	13 200	136 430	68 215	68 215
Thailand	0.10	498 770	44 000	454 770	227 385	227 385
Togo	0.01	49 880	4 400	45 480	22 740	22 740
Tonga	0.01	49 880	4 400	45 480	22 740	22 740
Trinidad and Tobago	0.03	149 630	13 200	136 430	68 215	68 215
Tunisia	0.03	149 630	13 200	136 430	68 215	68 215
Turkey	0.29	1 446 430	127 600	1 318 830	659 415	659 415
Uganda	0.01	49 880	4 400	45 480	22 740	22 740
Ukrainian Soviet Socialist Republic	1.44	7 182 300	633 600	6 548 700	3 274 350	3 274 350
Union of Soviet Socialist Republics	10.91	54 415 880	4 800 400	49 615 480	24 807 740	24 807 740
United Arab Emirates	0.10	498 770	44 000	454 770	227 385	227 385
United Kingdom of Great Britain and Northern Ireland	4.38	21 846 160	1 927 200	19 918 960	9 959 480	9 959 480
United Republic of Cameroon	0.01	49 880	4 400	45 480	22 740	22 740
United Republic of Tanzania	0.01	49 880	4 400	45 480	22 740	22 740
United States of America	25.00	124 692 700	3 002 000	121 690 700	60 845 350	60 845 350
Upper Volta	0.01	49 880	4 400	45 480	22 740	22 740
Uruguay	0.04	199 510	17 600	181 910	90 955	90 955
Venezuela	0.49	2 443 970	215 600	2 228 370	1 114 185	1 114 185
Viet Nam	0.03	149 630	13 200	136 430	68 215	68 215
Yemen	0.01	49 880	4 400	45 480	22 740	22 740
Yugoslavia	0.41	2 044 960	180 400	1 864 560	932 280	932 280
Zaire	0.02	99 750	8 800	90 950	45 475	45 475
Zambia	0.02	99 750	8 800	90 950	45 475	45 475
Zimbabwe	0.01	49 880	4 400	45 480	22 740	22 740
TOTAL	100.00	498 770 800	35 096 000	463 674 800	231 837 400	231 837 400

[a] Associate Member.

ANNEX 2

TRANSFER OF THE REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN[1]

1. ADVISORY OPINION OF THE INTERNATIONAL COURT OF JUSTICE

[A34/16 - 17 March 1981]

1. In compliance with resolution WHA33.16, adopted by the Thirty-third World Health Assembly on 20 May 1980, the Director-General submitted to the International Court of Justice, on 21 May 1980, the two questions formulated by the Organization regarding the interpretation of the Agreement of 25 March 1951 between WHO and Egypt.

2. On 20 December 1980 the Court delivered its Advisory Opinion, which is hereby submitted to the Health Assembly. A summary of the Opinion, reproducing verbatim the Court's findings as to the applicable legal principles and rules and the operative provision of the Opinion (paragraphs 43-51 of the Opinion), appears below. One copy of the full text of the Advisory Opinion, with the separate opinions appended by eight Judges and the dissenting opinion appended by one Judge, is being distributed separately to each delegation.

Summary of the Court's Opinion

Factual and legal background to the submission of the request (paras. 1-32 of the Advisory Opinion)

After detailing the various stages of the proceedings (paras. 1-9), the Court recounts the antecedents of the WHO Regional Office at Alexandria, from the creation in that city of a general Board of Health in 1831 for the purpose of preventing epidemics up to the integration of the Alexandria Sanitary Bureau with WHO in 1949 as a regional organ. The Eastern Mediterranean Regional Office commenced operations on 1 July 1949, while negotiations were in progress between WHO and Egypt for the conclusion of an agreement on the privileges, immunities and facilities to be granted to the Organization. This agreement was eventually signed on 25 March 1951 and entered into force on 8 August 1951 (paras. 10-27).

The Court next examines the events which led to the submission of the request for an Advisory Opinion. It recapitulates proceedings within WHO, from the recommendation by a Sub-Committee of the Regional Committee for the Eastern Mediterranean on 11 May 1979 that the Office be transferred to another State in the Region, up to the recommendation by the same Sub-Committee on 9 May 1980 that the Regional Office be transferred as soon as possible to Amman (Jordan) and the adoption by the World Health Assembly on 20 May 1980 of resolution WHA33.16 by which, on account of differing views as to the applicability of Section 37 of the Agreement of 25 March 1951 to the transfer of the Regional Office, it sought the Court's advisory opinion on two questions prior to taking any decision (paras. 28-32).

Competence to deliver an Opinion (para. 33)

Before going any further, the Court considers whether it ought to decline to reply to the request for an Advisory Opinion by reason of its allegedly political character. It concludes that to do so would run counter to its settled jurisprudence. If a question submitted in a request is one that otherwise falls within the normal exercise of its judicial powers, the Court has not to deal with the motives which may have inspired the request.

[1] See resolution WHA34.11.

Significance and scope of the questions put to the Court (paras. 34-36)

The Court next considers the meaning and implications of the hypothetical questions on which it is asked to advise. Section 37 of the Agreement of 25 March 1951, to which the first question refers, reads:

> "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 Court points out that, if it is to remain faithful to the requirements of its judicial character in the exercise of its advisory jurisdiction, it must ascertain what are the legal questions really in issue in questions formulated in a request. This it has had occasion to do in the past, as had also the Permanent Court of International Justice. The Court also notes that a reply to questions of the kind posed in the request submitted to it may, if incomplete, be not only ineffectual but actually misleading as to the legal rules applicable to the matter under consideration by WHO.

Having regard to the differing views expressed in the World Health Assembly on a number of points, it appears that the true legal question under consideration in the World Health Assembly, which must also be considered to be the legal question submitted to the Court in the WHO's request is:

> What are the legal principles and rules applicable to the question under what conditions and in accordance with what modalities a transfer of the Regional Office from Egypt may be effected?

The differing views advanced (paras. 37-42)

In answering the question thus formulated, the Court first notes that the right of an international organization to choose the location of its headquarters or regional office is not contested. It then turns to the differing views expressed in the World Health Assembly and, before the Court, in the written and oral statements, regarding the relevance of the Agreement of 25 March 1951 and the applicability of Section 37 to a transfer of the Regional Office from Egypt.

With respect to the relevance of the 1951 Agreement, one of the views advanced was that that agreement was a separate transaction, subsequent to the establishment of the Regional Office, and that, although it might contain references to the seat of the Regional Office in Alexandria, it did not provide for the Office's location there. It would follow that it had no bearing on the Organization's right to remove the Regional Office from Egypt. The Agreement, it was claimed, concerned the immunities and privileges granted to the Office within the larger context of the immunities and privileges granted by Egypt to WHO.

According to the opposing view, the establishment of the Regional Office and its integration with WHO were not completed in 1949; they were accomplished by a series of acts in a composite process, the final and definitive step in which was the conclusion of the 1951 host agreement. It was contended, inter alia, that the absence of a specific provision regarding the establishment of the WHO Office in Alexandria was due to the fact that the Agreement was dealing with a pre-existing Sanitary Bureau already established there. Moreover, it was stated, the Agreement was constantly referred to as a host agreement in the records of WHO and in official acts of the Egyptian State (paras. 37-39).

So far as the applicability of Section 37 to the transfer of the Office from Egypt was concerned, the differences of view resulted essentially from the meaning attributed to the word "revise" in the first sentence. According to one view, a transfer of the seat would not constitute a revision and would thus not be covered by Section 37, which would not apply to the denunciation of the Agreement which a transfer of the Office from Egypt would involve. Upholders of this view concluded therefrom that since there was no provision in the Agreement for denunciation, the general rules of international law which provided for the possibility of denunciation and the need for a period of notice in respect of such agreements applied in the present case. According to the opposite view, the word "revise" might also signify a general revision of an agreement, including its termination, and was so used in the 1951 Agreement. According to the proponents of this view, even if that interpretation was rejected, Egypt would still be entitled to receive notice under the general rules of international law.

Whatever view may be taken of the arguments advanced concerning the relevance and applicability of the 1951 Agreement, the Court finds that certain legal principles and rules are applicable in the case of such a transfer (paras. 40-42).

Applicable legal principles and rules (paras. 43-50)

"43. By the mutual understandings reached between Egypt and the Organization from 1949 to 1951 with respect to the Regional Office of the Organization in Egypt, whether they are regarded as distinct agreements or as separate parts of one transaction, a contractual legal régime was created between Egypt and the Organization which remains the basis of their legal relations today. Moreover, Egypt was a member - a founder member - of the newly-created World Health Organization when, in 1949, it transferred the operation of the Alexandria Sanitary Bureau to the Organization; and it has continued to be a member of the Organization ever since. The very fact of Egypt's membership of the Organization entails certain mutual obligations of co-operation and good faith incumbent upon Egypt and upon the Organization. Egypt offered to become host to the Regional Office in Alexandria and the Organization accepted that offer; Egypt agreed to provide the privileges, immunities and facilities necessary for the independence and effectiveness of the Office. As a result the legal relationship between Egypt and the Organization became, and now is, that of a host State and an international organization, the very essence of which is a body of mutual obligations of co-operation and good faith. In the present instance Egypt became host to the Organization's Regional Office, with its attendant advantages, and the Organization acquired a valuable seat for its office by the handing over to the Organization of an existing Egyptian Sanitary Bureau established in Alexandria, and the element of mutuality in the legal régime thus created between Egypt and the WHO is underlined by the fact that this was effected through common action based on mutual consent. This special legal régime of mutual rights and obligations has been in force between Egypt and WHO for over thirty years. The result is that there now exists in Alexandria a substantial WHO institution employing a large staff and discharging health functions important both to the Organization and to Egypt itself. In consequence, any transfer of the WHO Regional Office from the territory of Egypt necessarily raises practical problems of some importance. These problems are, of course, the concern of the Organization and of Egypt rather than of the Court. But they also concern the Court to the extent that they may have a bearing on the legal conditions under which a transfer of the Regional Office from Egypt may be effected.

"44. The problems were studied by the Working Group set up by the Executive Board of WHO in 1979, and it is evident from the report of that Working Group that much care and co-operation between the Organization and Egypt is needed if the risk of serious disruption to the health work of the Regional Office is to be avoided. It is also apparent that a reasonable period of time would be required to effect an orderly transfer of the operation of the Office from Alexandria to the new site without disruption to the work. Precisely what period of time would be required is a matter which can only be finally determined by consultation and negotiation between WHO and Egypt. It is, moreover, evident that during this period the Organization itself would need to make full use of the privileges, immunities and facilities provided in the Agreement of 25 March 1951 in order to ensure a smooth and orderly transfer of the Office from Egypt to its new site. In short, the situation arising in the event of a transfer of the Regional Office from Egypt is one which, by its very nature, demands consultation, negotiation and co-operation between the Organization and Egypt.

"45. The Court's attention has been drawn to a considerable number of host agreements of different kinds, concluded by States with various international organizations and containing varying provisions regarding the revision, termination or denunciation of the agreements. These agreements fall into two main groups: (1) those providing the necessary régime for the seat of a headquarters or regional office of a more or less permanent character, and (2) those providing a régime for other offices set up ad hoc and not envisaged as of a permanent character. As to the first group, which includes agreements concluded by the ILO and the WHO, their provisions take different forms. The headquarters agreement of the United Nations itself, with the United States, which leaves to the former the right to decide on its removal, provides for its termination if the seat is removed from the United States "except for such provisions as may be applicable in connection with the orderly termination of the operations of the United Nations at its seat in the United States and the disposition of its property therein". Other agreements similarly provide for cessation of the host agreement upon the removal of the seat, subject to arrangements for the orderly termination of the operations, while others, for example, provide for one year's or six months' notice of termination or denunciation, and there are other variants. The

ad hoc type of agreement, on the other hand, commonly provides for termination on short periods of notice or by agreement or simply on cessation of the operations subject to orderly arrangements for bringing them to an end.

"46. In considering these provisions, the Court feels bound to observe that in future closer attention might with advantage be given to their drafting. Nevertheless, despite their variety and imperfections, the provisions of host agreements regarding their revision, termination or denunciation are not without significance in the present connection. In the first place, they confirm the recognition by international organizations and host States of the existence of mutual obligations incumbent upon them to resolve the problems attendant upon a revision, termination or denunciation of a host agreement. But they do more, since they must be presumed to reflect the views of organizations and host States as to the implications of those obligations in the contexts in which the provisions are intended to apply. In the view of the Court, therefore, they provide certain general indications of what the mutual obligations of organizations and host States to co-operate in good faith may involve in situations such as the one with which the Court is here concerned.

"47. A further general indication as to what those obligations may entail is to be found in the second paragraph of Article 56 of the Vienna Convention on the Law of Treaties and the corresponding provision in the International Law Commission's draft articles on treaties between States and international organizations or between international organizations. Those provisions, as has been mentioned earlier, specifically provide that, when a right of denunciation is implied in a treaty by reason of its nature, the exercise of that right is conditional upon notice, and that of not less than twelve months. Clearly, these provisions also are based on an obligation to act in good faith and have reasonable regard to the interests of the other party to the treaty.

"48. In the present case, as the Court has pointed out, the true legal question submitted to it in the request is: What are the legal principles and rules applicable to the question under what conditions and in accordance with what modalities a transfer of the Regional Office from Egypt may be effected? Moreover, as it has also pointed out, differing views have been expressed concerning both the relevance in this connection of the 1951 Agreement and the interpretation of Section 37 of that Agreement. Accordingly, in formulating its reply to the request, the Court takes as its starting point the mutual obligations incumbent upon Egypt and the Organization to co-operate in good faith with respect to the implications and effects of the transfer of the Regional Office from Egypt. The Court does so the more readily as it considers those obligations to be the very basis of the legal relations between the Organization and Egypt under general international law, under the Constitution of the Organization and under the agreements in force between Egypt and the Organization. The essential task of the Court in replying to the request is, therefore, to determine the specific legal implications of the mutual obligations incumbent upon Egypt and the Organization in the event of either of them wishing to have the Regional Office transferred from Egypt.

"49. The Court considers that in the context of the present case the mutual obligations of the Organization and the host State to co-operate under the applicable legal principles and rules are as follows:

- In the first place, those obligations place a duty both upon the Organization and upon Egypt to consult together in good faith as to the question under what conditions and in accordance with what modalities a transfer of the Regional Office from Egypt may be effected.

- Secondly, in the event of its being finally decided that the Regional Office shall be transferred from Egypt; their mutual obligations of co-operation place a duty upon the Organization and Egypt to consult together and to negotiate regarding the various arrangements needed to effect the transfer from the existing to the new site in an orderly manner and with a minimum of prejudice to the work of the Organization and the interests of Egypt.

- Thirdly, those mutual obligations place a duty upon the party which wishes to effect the transfer to give a reasonable period of notice to the other party for the termination of the existing situation regarding the Regional Office at Alexandria, taking due account of all the practical arrangements needed to effect an orderly and equitable transfer of the Office to its new site.

Those, in the view of the Court, are the implications of the general legal principles and rules applicable in the event of the transfer of the seat of a Regional Office from the territory of a host State. Precisely what periods of time may be involved in the observance of the duties to consult and negotiate, and what period of notice of termination should be given, are matters which necessarily vary according to the requirements of the particular case. In principle, therefore, it is for the parties in each case to determine the length of those periods by consultation and negotiation in good faith. Some indications as to the possible periods involved, as the Court has said, can be seen in provisions of host agreements, including Section 37 of the Agreement of 25 March 1951, as well as in Article 56 of the Vienna Convention on the Law of Treaties and in the corresponding article of the International Law Commission's draft articles on treaties between States and international organizations or between international organizations. But what is reasonable and equitable in any given case must depend on its particular circumstances. Moreover, the paramount consideration both for the Organization and the host State in every case must be their clear obligation to co-operate in good faith to promote the objectives and purposes of the Organization as expressed in its Constitution; and this too means that they must in consultation determine a reasonable period of time to enable them to achieve an orderly transfer of the Office from the territory of the host State.

"50. It follows that the Court's reply to the second question is that the legal responsibilities of the Organization and Egypt during the transitional period between the notification of the proposed transfer of the Office and the accomplishment thereof would be to fulfil in good faith the mutual obligations which the Court has set out in answering the first question."

Operative Provision of the Advisory Opinion (para. 51)

"51. For these reasons,

THE COURT,

1. By twelve votes to one,

Decides to comply with the request for an advisory opinion;

IN FAVOUR: President Sir Humphrey Waldock; Vice-President Elias; Judges Forster, Gros, Lachs, Nagendra Singh, Ruda, Mosler, Oda, Ago, El-Erian and Sette-Camara;

AGAINST: Judge Morozov

2. With regard to Question 1,

By twelve votes to one,

Is of the opinion that in the event specified in the request, the legal principles and rules, and the mutual obligations which they imply, regarding consultation, negotiation and notice, applicable as between the World Health Organization and Egypt are those which have been set out in paragraph 49 of this Advisory Opinion and in particular that:

(a) their mutual obligations under those legal principles and rules place a duty both upon the Organization and upon Egypt to consult together in good faith as to the question under what conditions and in accordance with what modalities a transfer of the Regional Office from Egypt may be effected;

(b) in the event of its being finally decided that the Regional Office shall be transferred from Egypt, their mutual obligations of co-operation place a duty upon the Organization and Egypt to consult together and to negotiate regarding the various arrangements needed to effect the transfer from the existing to the new site in an orderly manner and with a minimum of prejudice to the work of the Organization and the interests of Egypt;

(c) their mutual obligations under those legal principles and rules place a duty upon the party which wishes to effect the transfer to give a reasonable period of notice to the other party for the termination of the existing situation regarding the Regional Office at Alexandria, taking due account of all the practical arrangements needed to effect an orderly and equitable transfer of the Office to its new site;

IN FAVOUR: President Sir Humphrey Waldock; Vice-President Elias; Judges Forster, Gros, Lachs, Nagendra Singh, Ruda, Mosler, Oda, Ago, El-Erian and Sette Camara;

AGAINST: Judge Morozov;

3. With regard to Question 2,

By eleven votes to two,

Is of the opinion that, in the event of a decision that the Regional Office shall be tranferred from Egypt, the legal responsibilities of the World Health Organization and Egypt during the transitional period between the notification of the proposed transfer of the Office and the accomplishment thereof are to fulfil in good faith the mutual obligations which the Court has set out in answering Question 1;

IN FAVOUR: President Sir Humphrey Waldock; Vice-President Elias; Judges Forster, Gros, Nagendra Singh, Ruda, Mosler, Oda, Ago, El-Erian and Sette-Camara;

AGAINST: Judges Lachs and Morozov".

2. COMMUNICATION RECEIVED BY THE DIRECTOR-GENERAL FROM DELEGATIONS OF 17 MEMBER STATES OF THE EASTERN MEDITERRANEAN REGION

[A34/INF.DOC./14 Rev.1 - 21 May 1981]

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

ORIGINAL: ARABIC

19 May 1981

Dear Sir,

In consideration of the resolution adopted by the World Health Assembly on 18 May 1981, we Member States in Sub-Committee A of the Eastern Mediterranean Region would be grateful if you could accelerate the implementation of the Assembly's request concerning the initiation of action as contained in paragraph 51 of the Advisory Opinion, and could keep informed the States of the Region which are members of Sub-Committee A.

The undersigned States find themselves compelled, at the current stage, to completely boycott the Regional Office in its present location in Alexandria and not to have any dealings with it, until a final decision is taken by the World Health Assembly concerning the transfer.

We hereby assure you that we adhere to the text of our letter to you of 19 May 1980, of which a copy is attached.[1]

We request the circulation of this communication to all delegations participating in the Thirty-fourth World Health Assembly.

With best regards,

(signed)

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

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[1] Reproduced in document WHA33/1980/REC/1, Annex 2, section 8.

ANNEX 3

DRAFT INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES[1]

/A34/8 - 23 March 1981/

Report by the Director-General

1. The Thirty-third World Health Assembly (1980), in resolution WHA33.32, requested the Director-General inter alia to "prepare an international code of marketing of breast-milk substitutes" and 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".

2. The Director-General submitted to the Executive Board a report (document EB67/20 - see Appendix) in which he outlined the development of the draft International Code of Marketing of Breast-milk Substitutes and presented the draft Code in the form of a regulation and a recommendation. In endorsing the draft International Code in its entirety, the Executive Board forwarded it to the Health Assembly and unanimously recommended that it be adopted in the sense of Article 23 of the Constitution.[2] The Board's resolution EB67.R12[3] contains the draft resolution it has recommended for adoption by the Thirty-fourth World Health Assembly in this respect.

Appendix

REPORT BY THE DIRECTOR-GENERAL TO THE EXECUTIVE BOARD

/EB67/20 - 10 December 1980/

1. INTRODUCTION

1.1 A joint WHO/UNICEF Meeting on Infant and Young Child Feeding was held in Geneva from 9 to 12 October 1979 as part of the two organizations' programmes aimed at promoting child health and nutrition. It was attended by representatives of governments, agencies of the United Nations system, nongovernmental organizations, the infant food industry, and experts in related disciplines.

1.2 The discussions were organized around the following themes: the encouragement and support of breast-feeding; the promotion and support of appropriate and timely complementary feeding (weaning) practices with the use of local food resources; the strengthening of education,

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[1] See resolution WHA34.22.

[2] In accordance with the Board's proposal, the Code was adopted in the form of a recommendation; the text appears in section 4 of the Appendix to this Annex.

[3] Document EB67/1981/REC/1, p. 9.

training and information on infant and young child feeding; the development of support for improved health and social status of women in relation to infant and young child health and feeding; and the development of appropriate marketing and distribution of breast-milk substitutes.

1.3 As a result of the discussions, a statement on infant and young child feeding, together with a series of recommendations, was prepared and adopted by consensus. The statement and recommendations were first sent by the Director-General to all governments in November 1979; they were also appended to the Director-General's report[1] to the Thirty-third World Health Assembly on follow-up activities undertaken by WHO after the October 1979 Meeting in respect of the above five discussion themes.

1.4 The Thirty-third World Health Assembly, in resolution WHA33.32, endorsed in their entirety the statement and recommendations made by the joint WHO/UNICEF Meeting; made particular mention of the recommendation that "there should be an international code of marketing of infant formula and other products used as breast-milk substitutes"; and requested the Director-General to prepare such a code "in close consultation with Member States and all other parties concerned including such scientific and other experts whose collaboration may be deemed appropriate".

1.5 The present report describes the action taken by WHO in relation to the development of the draft International Code of Marketing of Breast-milk Substitutes. It also outlines the legal and other implications of the adoption of the draft International Code as a regulation or a recommendation.

2. PROCESS OF DEVELOPMENT OF THE DRAFT INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES

2.1 Following the recommendation made by the joint WHO/UNICEF Meeting concerning the development of an international code of marketing of infant formula and other products used as breast-milk substitutes, a first draft of the Code had been formulated and sent by the Director-General of the World Health Organization and the Executive Director of UNICEF to all Member States in February 1980 with the request that comments and observations be sent to the Director-General of WHO by 31 March 1980. A series of consultations was held with interested parties (governments, agencies of the United Nations system, nongovernmental organizations, the infant food industry, and experts) concerning the form and content of the first draft. Based on the comments received from governments and the suggestions made during the consultations, a second draft of the International Code was prepared and made available to the Thirty-third World Health Assembly as an addendum to the report of the Director-General on the follow-up of the joint WHO/UNICEF Meeting on Infant and Young Child Feeding.[2]

2.2 Following the Thirty-third World Health Assembly, the Director-General of WHO and the Executive Director of UNICEF sent a circular letter to all Member States requesting their comments on the second draft of the International Code as it had been presented to the Health Assembly. Furthermore, all participants in the joint WHO/UNICEF Meeting and in the consultations held in February and March 1980 were asked to comment on this draft.

2.3 In compliance with resolution WHA33.32, and taking into account statements made by delegates at the Health Assembly and comments provided by governments and other interested parties, a third draft of the International Code was prepared and discussed at two additional consultations. The first of these was held in Geneva on 28-29 August 1980, when participants included representatives of agencies of the United Nations, nongovernmental organizations, the infant food industry, and experts. The second consultation was held in Geneva on 25-26 September 1980, with representatives of selected Member States. Summaries of the proceedings of the August and September consultations, as well as the third draft of the International Code, were sent for information to all Member States.

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[1] "Follow-up of WHO/UNICEF Meeting on Infant and Young Child Feeding" - document A33/6, reproduced as Annex 6 in document WHA33/1980/REC/1.

[2] Document A33/6 Add. 1.

2.4 In the process of preparing the draft International Code, the work done by organizations and bodies of the United Nations system in the field of infant and young child nutrition has been taken into consideration. For example, use has been made of the work of the Joint FAO/WHO Food Standards Programme and its Codex Alimentarius Commission, in particular with regard to international standards for foods for infants and children and the development of suitable definitions for the purposes of the draft International Code. The secretariat of the Codex Alimentarius Commission, in turn, has been actively involved in the consultations with the interested parties referred to above.

3. THE LEGAL AND OTHER IMPLICATIONS OF THE ADOPTION OF THE DRAFT INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES AS A REGULATION OR AS A RECOMMENDATION

3.1 The legal implications which may arise from the adoption of the draft International Code as a regulation are as follows:

(1) In accordance with Article 22 of the Constitution of the World Health Organization, regulations adopted under Article 21 come into force for all Members of the Organization after due notice has been given of their adoption by the Health Assembly, except for such Members as may notify the Director-General of rejection or reservations within the period of notice specified by the Health Assembly. Consequently, the Code would have a binding effect without the need for ratification, acceptance or approval by each Member. Any rejection or reservation received by the Director-General after the expiry of the notice period would have no effect. It would be for each Member State bound by the regulation to determine what legal framework it wished to give to the regulation, e.g. enact a statute or regulations.

(2) As a consequence of (1) above, the provisions of the Code would lay down specific rules intended to impose specific obligations. Therefore, the provisions of the Code would use, generally, the term "shall", together with other appropriate language, to give effect to its intent.

(3) In accordance with Article 62 of the Constitution of the Organization, Member States are required to report annually to the Organization on action taken with respect to regulations adopted by the Health Assembly. Therefore, Member States would have to report to the Organization, for example, on legislation, national regulations or other appropriate measures adopted by their competent organs to give effect to the Code.

(4) The majority required for the adoption of the Code as a regulation under Article 21 of the Constitution is a simple majority, in accordance with Article 60, paragraph (b), of the Constitution, and Rule 73 of the Rules of Procedure of the World Health Assembly.

(5) If the Code is adopted as a regulation, then it would have to contain final clauses dealing with its entry-into-force, notice period for making reservations or indicating rejection, withdrawal of such reservations or rejection, notification of the Director-General to Member States of the adoption of the Code as a regulation or any amendment thereof, and so forth.

(6) If the Code is adopted as a regulation, then the need would probably arise for a machinery for the settlement of disputes concerning the interpretation or the application of this Code.

(7) If the Code is adopted as a regulation, then, following the practice of the World Health Organization, it would be registered with the United Nations Secretariat, in accordance with Article 102 of the United Nations Charter, as an international agreement.

3.2 The legal implications which may arise from the adoption of the draft International Code as a recommendation are as follows:

(1) Recommendations of the Health Assembly are not legally binding on Member States per se. However, recommendations may become binding on Member States with their consent, in which case they may give effect to them in any legal framework they deem appropriate,

e.g. regulations, by-laws. On the other hand, recommendations of the Health Assembly carry some moral or political weight, as they constitute the judgement of the collective membership of the Organization. Member States do not have to notify WHO of their reservations or rejection of recommendations of the Health Assembly as they do for regulations.

(2) As a consequence of (1) above, the provisions of recommendations would lay down general principles, provide advice, and call on Members to take a certain stand on technical matters and other public health questions. Thus the language of the Code would be, generally, recommendatory in nature, and would use the term "should".

(3) The majority required for the adoption of the Code as a recommendation under Article 23 of the Constitution is a simple majority, in accordance with Article 60, paragraph (b), of the Constitution, and Rule 73 of the Rules of Procedure of the World Health Assembly.

(4) If the Code is adopted by the Health Assembly as a recommendation, then, in view of the usual procedure relating to recommendations, there would be no need for final clauses to be incorporated in the Code.

(5) For the reasons mentioned in (1) and (4), there would be no need for a machinery for the settlement of disputes.

(6) If the Code is adopted as a recommendation, there would be no need to register it with the United Nations Secretariat in accordance with Article 102 of the United Nations Charter. The latter provision requires the registration of treaties and international agreements only. A recommendation is neither of these.

(7) If the Code is adopted as a recommendation, then, as in the case with regulations, Member States would be required to report annually to the Organization on the action taken with respect to the Code, in accordance with Article 62 of the Constitution of the Organization. A Member State may, for example, report on the submission of the Code to the appropriate national authority for action, or it may notify WHO of the incorporation of the Code in national regulations.

3.3 It is anticipated that the financial and administrative implications for the Organization will be approximately of the same order whether the draft International Code is adopted in the form of a regulation or in the form of a recommendation.

4. INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES[1]

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[1] As adopted in recommendation form in the sense of Article 23 of the Constitution. The text of the draft Code in regulation form is not reproduced here.

The Member States of the World Health Organization:

Affirming the right of every child and every pregnant and lactating woman to be adequately nourished as a means of attaining and maintaining health;

Recognizing that infant malnutrition is part of the wider problems of lack of education, poverty, and social injustice;

Recognizing that the health of infants and young children cannot be isolated from the health and nutrition of women, their socioeconomic status and their roles as mothers;

Conscious that breast-feeding is an unequalled way of providing ideal food for the healthy growth and development of infants; that it forms a unique biological and emotional basis for the health of both mother and child; that the anti-infective properties of breast milk help to protect infants against disease; and that there is an important relationship between breast-feeding and child-spacing;

Recognizing that the encouragement and protection of breast-feeding is an important part of the health, nutrition and other social measures required to promote healthy growth and development of infants and young children; and that breast-feeding is an important aspect of primary health care;

Considering that when mothers do not breast-feed, or only do so partially, there is a legitimate market for infant formula and for suitable ingredients from which to prepare it; that all these products should accordingly be made accessible to those who need them through commercial or non-commercial distribution systems; and that they should not be marketed or distributed in ways that may interfere with the protection and promotion of breast-feeding;

Recognizing further that inappropriate feeding practices lead to infant malnutrition, morbidity and mortality in all countries, and that improper practices in the marketing of breast-milk substitutes and related products can contribute to these major public health problems;

Convinced that it is important for infants to receive appropriate complementary foods, usually when the infant reaches four to six months of age, and that every effort should be made to use locally available foods; and convinced, nevertheless, that such complementary foods should not be used as breast-milk substitutes;

Appreciating that there are a number of social and economic factors affecting breast-feeding, and that, accordingly, governments should develop social support systems to protect, facilitate and encourage it, and that they should create an environment that fosters breast-feeding, provides appropriate family and community support, and protects mothers from factors that inhibit breast-feeding;

Affirming that health care systems, and the health professionals and other health workers serving in them, have an essential role to play in guiding infant feeding practices, encouraging and facilitating breast-feeding, and providing objective and consistent advice to mothers and families about the superior value of breast-feeding, or, where needed, on the proper use of infant formula, whether manufactured industrially or home-prepared;

Affirming further that educational systems and other social services should be involved in the protection and promotion of breast-feeding, and in the appropriate use of complementary foods;

Aware that families, communities, women's organizations and other nongovernmental organizations have a special role to play in the protection and promotion of breast-feeding and in ensuring the support needed by pregnant women and mothers of infants and young children, whether breast-feeding or not;

Affirming the need for governments, organizations of the United Nations system, nongovernmental organizations, experts in various related disciplines, consumer groups and

industry to cooperate in activities aimed at the improvement of maternal, infant and young child health and nutrition;

Recognizing that governments should undertake a variety of health, nutrition and other social measures to promote healthy growth and development of infants and young children, and that this Code concerns only one aspect of these measures;

Considering that manufacturers and distributors of breast-milk substitutes have an important and constructive role to play in relation to infant feeding, and in the promotion of the aim of this Code and its proper implementation;

Affirming that governments are called upon to take action appropriate to their social and legislative framework and their overall development objectives to give effect to the principles and aim of this Code, including the enactment of legislation, regulations or other suitable measures;

Believing that, in the light of the foregoing considerations, and in view of the vulnerability of infants in the early months of life and the risks involved in inappropriate feeding practices, including the unnecessary and improper use of breast-milk substitutes, the marketing of breast-milk substitutes requires special treatment, which makes usual marketing practices unsuitable for these products;

THEREFORE:

The Member States hereby agree the following articles which are recommended as a basis for action.

Article 1. Aim of the Code

The aim of this Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breast-feeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.

Article 2. Scope of the Code

The Code applies to the marketing, and practices related thereto, of the following products: breast-milk substitutes, including infant formula; other milk products, foods and beverages, including bottle-fed complementary foods, when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breast milk; feeding bottles and teats. It also applies to their quality and availability, and to information concerning their use.

Article 3. Definitions

For the purposes of this Code:

"Breast-milk substitute"	means	any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose.
"Complementary food"	means	any food, whether manufactured or locally prepared, suitable as a complement to breast milk or to infant formula, when either becomes insufficient to satisfy the nutritional requirements of the infant. Such food is also commonly called "weaning food" or "breast-milk supplement".

"Container"	means	any form of packaging of products for sale as a normal retail unit, including wrappers.
"Distributor"	means	a person, corporation or any other entity in the public or private sector engaged in the business (whether directly or indirectly) of marketing at the wholesale or retail level a product within the scope of this Code. A "primary distributor" is a manufacturer's sales agent, representative, national distributor or broker.
"Health care system"	means	governmental, nongovernmental or private institutions or organizations engaged, directly or indirectly, in health care for mothers, infants and pregnant women; and nurseries or child-care institutions. It also includes health workers in private practice. For the purposes of this Code, the health care system does not include pharmacies or other established sales outlets.
"Health worker"	means	a person working in a component of such a health care system, whether professional or non-professional, including voluntary, unpaid workers.
"Infant formula"	means	a breast-milk substitute formulated industrially in accordance with applicable Codex Alimentarius standards, to satisfy the normal nutritional requirements of infants up to between four and six months of age, and adapted to their physiological characteristics. Infant formula may also be prepared at home, in which case it is described as "home-prepared".
"Label"	means	any tag, brand, mark, pictorial or other descriptive matter, written, printed, stencilled, marked, embossed or impressed on, or attached to, a container (see above) of any products within the scope of this Code.
"Manufacturer"	means	a corporation or other entity in the public or private sector engaged in the business or function (whether directly or through an agent or through an entity controlled by or under contract with it) of manufacturing a product within the scope of this Code.
"Marketing"	means	product promotion, distribution, selling, advertising, product public relations, and information services.
"Marketing personnel"	means	any persons whose functions involve the marketing of a product or products coming within the scope of this Code.
"Samples"	means	single or small quantities of a product provided without cost.
"Supplies"	means	quantities of a product provided for use over an extended period, free or at a low price, for social purposes, including those provided to families in need.

Article 4. Information and education

4.1 Governments should have the responsibility to ensure that objective and consistent information is provided on infant and young child feeding for use by families and those involved in the field of infant and young child nutrition. This responsibility should cover either the planning, provision, design and dissemination of information, or their control.

4.2 Informational and educational materials whether written, audio, or visual, dealing with the feeding of infants and intended to reach pregnant women and mothers of infants and young children, should include clear information on all the following points: (a) the benefits and superiority of breast-feeding: (b) maternal nutrition, and the preparation for and maintenance of breast-feeding; (c) the negative effect on breast-feeding of introducing partial bottle-feeding; (d) the difficulty of reversing the decision not to breast-feed; and (e) where needed, the proper use of infant formula, whether manufactured industrially or home-prepared. When such materials contain information about the use of infant formula, they should include the social and financial implications of its use; the health hazards of inappropriate foods or feeding methods; and, in particular, the health hazards of unnecessary or improper use of infant formula and other breast-milk substitutes. Such materials should not use any pictures or text which may idealize the use of breast-milk substitutes.

4.3 Donations of informational or educational equipment or materials by manufacturers or distributors should be made only at the request and with the written approval of the appropriate government authority or within guidelines given by governments for this purpose. Such equipment or materials may bear the donating company's name or logo, but should not refer to a proprietary product that is within the scope of this Code, and should be distributed only through the health care system.

Article 5. The general public and mothers

5.1 There should be no advertising or other form of promotion to the general public of products within the scope of this Code.

5.2 Manufacturers and distributors should not provide, directly or indirectly, to pregnant women, mothers or members of their families, samples of products within the scope of this Code.

5.3 In conformity with paragraphs 1 and 2 of this Article, there should be no point-of-sale advertising, giving of samples, or any other promotion device to induce sales directly to the consumer at the retail level, such as special displays, discount coupons, premiums, special sales, loss-leaders and tie-in sales, for products within the scope of this Code. This provision should not restrict the establishment of pricing policies and practices intended to provide products at lower prices on a long-term basis.

5.4 Manufacturers and distributors should not distribute to pregnant women or mothers of infants and young children any gifts of articles or utensils which may promote the use of breast-milk substitutes or bottle-feeding.

5.5 Marketing personnel, in their business capacity, should not seek direct or indirect contact of any kind with pregnant women or with mothers of infants and young children.

Article 6. Health care systems

6.1 The health authorities in Member States should take appropriate measures to encourage and protect breast-feeding and promote the principles of this Code, and should give appropriate information and advice to health workers in regard to their responsibilities, including the information specified in Article 4.2.

6.2 No facility of a health care system should be used for the purpose of promoting infant formula or other products within the scope of this Code. This Code does not, however, preclude the dissemination of information to health professionals as provided in Article 7.2.

6.3 Facilities of health care systems should not be used for the display of products within the scope of this Code, for placards or posters concerning such products, or for the distribution of material provided by a manufacturer or distributor other than that specified in Article 4.3.

6.4 The use by the health care system of "professional service representatives", "mothercraft nurses" or similar personnel, provided or paid for by manufacturers or distributors, should not be permitted.

6.5 Feeding with infant formula, whether manufactured or home-prepared, should be demonstrated only by health workers, or other community workers if necessary; and only to the mothers or family members who need to use it; and the information given should include a clear explanation of the hazards of improper use.

6.6 Donations or low-price sales to institutions or organizations of supplies of infant formula or other products within the scope of this Code, whether for use in the institutions or for distribution outside them, may be made. Such supplies should only be used or distributed for infants who have to be fed on breast-milk substitutes. If these supplies are distributed for use outside the institutions, this should be done only by the institutions or organizations concerned. Such donations or low-price sales should not be used by manufacturers or distributors as a sales inducement.

6.7 Where donated supplies of infant formula or other products within the scope of this Code are distributed outside an institution, the institution or organization should take steps to ensure that supplies can be continued as long as the infants concerned need them. Donors, as well as institutions or organizations concerned, should bear in mind this responsibility.

6.8 Equipment and materials, in addition to those referred to in Article 4.3, donated to a health care system may bear a company's name or logo, but should not refer to any proprietary product within the scope of this Code.

Article 7. Health workers

7.1 Health workers should encourage and protect breast-feeding; and those who are concerned in particular with maternal and infant nutrition should make themselves familiar with their responsibilities under this Code, including the information specified in Article 4.2

7.2 Information provided by manufacturers and distributors to health professionals regarding products within the scope of this Code should be restricted to scientific and factual matters, and such information should not imply or create a belief that bottle-feeding is equivalent or superior to breast-feeding. It should also include the information specified in Article 4.2.

7.3 No financial or material inducements to promote products within the scope of this Code should be offered by manufacturers or distributors to health workers or members of their families, nor should these be accepted by health workers or members of their families.

7.4 Samples of infant formula or other products within the scope of this Code, or of equipment or utensils for their preparation or use, should not be provided to health workers except when necessary for the purpose of professional evaluation or research at the institutional level. Health workers should not give samples of infant formula to pregnant women, mothers of infants and young children, or members of their families.

7.5 Manufacturers and distributors of products within the scope of this Code should disclose to the institution to which a recipient health worker is affiliated any contribution made to him or on his behalf for fellowships, study tours, research grants, attendance at professional conferences, or the like. Similar disclosures should be made by the recipient.

Article 8. Persons employed by manufacturers and distributors

8.1 In systems of sales incentives for marketing personnel, the volume of sales of products within the scope of this Code should not be included in the calculation of bonuses, nor should quotas be set specifically for sales of these products. This should not be understood to prevent the payment of bonuses based on the overall sales by a company of other products marketed by it.

8.2 Personnel employed in marketing products within the scope of this Code should not, as part of their job responsibilities, perform educational functions in relation to pregnant women or mothers of infants and young children. This should not be understood as preventing such personnel from being used for other functions by the health care system at the request and with the written approval of the appropriate authority of the government concerned.

Article 9. Labelling

9.1 Labels should be designed to provide the necessary information about the appropriate use of the product, and so as not to discourage breast-feeding.

9.2 Manufacturers and distributors of infant formula should ensure that each container has a clear, conspicuous, and easily readable and understandable message printed on it, or on a label which cannot readily become separated from it, in an appropriate language, which includes all the following points: (a) the words "Important Notice" or their equivalent; (b) a statement of the superiority of breast-feeding; (c) a statement that the product should be used only on the advice of a health worker as to the need for its use and the proper method of use; (d) instructions for appropriate preparation, and a warning against the health hazards of inappropriate preparation. Neither the container nor the label should have pictures of infants, nor should they have other pictures or text which may idealize the use of infant formula. They may, however, have graphics for easy identification of the product as a breast-milk substitute and for illustrating methods of preparation. The terms "humanized", "maternalized" or similar terms should not be used. Inserts giving additional information about the product and its proper use, subject to the above conditions, may be included in the package or retail unit. When labels give instructions for modifying a product into infant formula, the above should apply.

9.3 Food products within the scope of this Code, marketed for infant feeding, which do not meet all the requirements of an infant formula, but which can be modified to do so, should carry on the label a warning that the unmodified product should not be the sole source of nourishment of an infant. Since sweetened condensed milk is not suitable for infant feeding, nor for use as a main ingredient of infant formula, its label should not contain purported instructions on how to modify it for that purpose.

9.4 The label of food products within the scope of this Code should also state all the following points: (a) the ingredients used; (b) the composition/analysis of the product; (c) the storage conditions required; and (d) the batch number and the date before which the product is to be consumed, taking into account the climatic and storage conditions of the country concerned.

Article 10. Quality

10.1 The quality of products is an essential element for the protection of the health of infants and therefore should be of a high recognized standard.

10.2 Food products within the scope of this Code should, when sold or otherwise distributed, meet applicable standards recommended by the Codex Alimentarius Commission and also the Codex Code of Hygienic Practice for Foods for Infants and Children.

Article 11. Implementation and monitoring

11.1 Governments should take action to give effect to the principles and aim of this Code, as appropriate to their social and legislative framework, including the adoption of national legislation, regulations or other suitable measures. For this purpose, governments should seek, when necessary, the cooperation of WHO, UNICEF and other agencies of the United Nations system. National policies and measures, including laws and regulations, which are adopted to

give effect to the principles and aim of this Code should be publicly stated, and should apply on the same basis to all those involved in the manufacture and marketing of products within the scope of this Code.

11.2 Monitoring the application of this Code lies with governments acting individually, and collectively through the World Health Organization as provided in paragraphs 6 and 7 of this Article. The manufacturers and distributors of products within the scope of this Code, and appropriate nongovernmental organizations, professional groups, and consumer organizations should collaborate with governments to this end.

11.3 Independently of any other measures taken for implementation of this Code, manufacturers and distributors of products within the scope of this Code should regard themselves as responsible for monitoring their marketing practices according to the principles and aim of this Code, and for taking steps to ensure that their conduct at every level conforms to them.

11.4 Nongovernmental organizations, professional groups, institutions, and individuals concerned should have the responsibility of drawing the attention of manufacturers or distributors to activities which are incompatible with the principles and aim of this Code, so that appropriate action can be taken. The appropriate governmental authority should also be informed.

11.5 Manufacturers and primary distributors of products within the scope of this Code should apprise each member of their marketing personnel of the Code and of their responsibilities under it.

11.6 In accordance with Article 62 of the Constitution of the World Health Organization, Member States shall communicate annually to the Director-General information on action taken to give effect to the principles and aim of this Code.

11.7 The Director-General shall report in even years to the World Health Assembly on the status of implementation of the Code; and shall, on request, provide technical support to Member States preparing national legislation or regulations, or taking other appropriate measures in implementation and furtherance of the principles and aim of this Code.

ANNEX 4

REPORT OF THE DIRECTOR-GENERAL ON THE WORK OF WHO IN 1980[1]

/A34/3 - 1 April 1981/

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Introduction

1. "To ensure implementation, debate has to give way to action." This was what the Executive Board had to say when it submitted its draft of the Global Strategy for health for all by the year 2000 to the Thirty-fourth World Health Assembly.

[1] See decision WHA34(9).

2. 1980 was a year in which the way to action for health for all by the year 2000 was clearly demarcated. For, in that year, tens of countries, developed and developing alike, addressed themselves seriously to the preparation of national strategies for attaining health for all their people. In a world plagued by cynicism, this phenomenon alone would suffice to warrant devoting a whole annual report to it; for it shows that the Member States of WHO are taking seriously their responsibility for the health of their people. Moreover, during 1980 these same Member States approved in their respective regional committees regional strategies to support their own individual strategies. And finally, at the Thirty-fourth World Health Assembly in May 1981 they will be considering a Global Strategy[1] submitted to them by WHO's Executive Board.

3. What are these strategies all about? In spite of wide national and regional variations, which are only to be expected in view of the widely different circumstances of each country and region, certain themes have emerged that are common to them all. Thus, the need has become clear to develop health systems that encompass the entire population on a basis of equality and responsibility. Such systems include components from the health sector and from other sectors whose interrelated actions contribute to health. These systems are based on primary health care as defined in the Declaration of Alma-Ata, delivered at the first point of contact between individuals and the health system. Other levels of the health system support the first contact level of primary health care to permit it to provide these essential elements on a continuing basis.

4. To build up such health systems implies establishing a well-coordinated infrastructure, starting with family and community care, and continuing with intermediate and central support and referral levels. This infrastructure will have to deliver well-defined health programmes that cover the whole population, progressively if necessary. These programmes will have to use technology that is scientifically sound, adaptable to various local circumstances, acceptable to those for whom it is used and to those who use it, and maintainable with resources the country can afford. Health manpower will have to be planned, trained and deployed in response to specific needs of people as an integral part of the health infrastructure. Action will have to be taken not only in the health sector, but also in other relevant social and economic sectors. Such action will have to include measures for health promotion, not the least of which will consist of promoting healthy lifestyles and habits. Measures to make sure that all preventable disease is indeed prevented will also have to be included. Great care will have to be taken to ensure that diagnostic, therapeutic and rehabilitative measures are really appropriate for the country in which they are applied.

5. The above is far from being the conventional way of providing health care in most countries, so the introduction of such health systems will not follow simply from enunciating their principles or planning them on paper. Crucial to the strategies, therefore, is making sure of social control of the health infrastructure and technology through a high degree of community involvement. Such social control will naturally have to be applied by each country in a manner that is consonant with its political, cultural and administrative traditions. As the synthesis of the Global Strategy from the national and regional strategies has shown, political commitment at the highest government level as well as the support of economic development planners will have to be ensured, and professional groups inside and outside the health sector will have to be enlisted. An appropriate managerial process for national health development and the related health systems research will have to be applied, and health research in general oriented to support the strategies. Information will have to be widely disseminated to policy makers, to professional people in the health and related sectors, and to the public at large, to ensure acceptance of the strategies by them and thus encourage their involvement. These measures will have to be supplemented by additional ones to ensure the mobilization of all human resources, not only health personnel. The best use will also have to be made of available financial resources, and additional resources generated, if these strategies are to have a chance of succeeding.

6. As the preparation of the strategies has clearly shown, all the above-mentioned actions in countries by countries will have to be supported by international action. The most

[1] Adopted in resolution WHA34.36 and subsequently published as: Global Strategy for health for all by the year 2000. Geneva, World Health Organization, 1981 ("Health for All" Series, No. 3).

important international action will consist of cooperation among countries. The pledges made throughout the year by developing and developed countries alike to cooperate among themselves in support of the health for all movement is, to say the least, highly encouraging. These include pledges of good will to ensure that the international transfer of resources for health from developed to developing countries is channelled into priority activities in the strategies of these latter countries.

7. What are the chances of success of such a Strategy? The knowledge is for the most part available; its application, however, has never been guaranteed until now. Such a guarantee depends on the world's political, socioeconomic and health leaders taking the Strategy seriously, ensuring the intercountry cooperation required, and making available the necessary resources.

8. In the course of 1980, WHO's unique role was identified again and again in connexion with the development of strategies for health for all, their support, their coordination, the monitoring of their progress, and the evaluation of their impact. The Organization has been preparing itself over the past few years to fulfil its heightened role in support of the efforts of its Member States to attain an acceptable level of health for all their people. To this end, a worldwide managerial study of unprecedented proportions was carried out, namely the study of WHO's structures in the light of its functions. It was summarized in a historical resolution of the Thirty-third World Health Assembly which will no doubt shape the way the Organization will work over the next decade or two.[1] Behind the tidy façade of the Health Assembly's resolution lies a profound reawakening of the original intention of WHO's founders when they adopted a Constitution based on cooperation among Member States to promote and protect the health of all peoples. For the Health Assembly's resolution has restated and reinstated the unique democratic features of WHO's way of life, whereby Member States assume total responsibility for their collective action and undertake to carry out their own health activities in the spirit of the policies and programmes they have adopted collectively in WHO.

9. And now for some of the details. Convinced that through its international health work WHO can be a powerful instrument in helping to reduce international tension, to overcome racial and social discrimination, and to promote peace, the Health Assembly decided to concentrate the Organization's activities over the coming decades on support to national, regional and global strategies for health for all, including the exercise of its influence to channel all available health resources towards this end. This implies strengthening the roles of the Organization in promoting action for health in addition to indicating how such action might be carried out. It was clear to the Assembly that if the Organization was to succeed in fulfilling its tasks adequately, its directing, coordinating and technical cooperation functions would have to be mutually supportive, and that the work of the Organization at all levels would have to be properly interrelated.

10. In adopting the resolution, Member States undertook to strengthen their ministries of health as necessary so that these could fully assume the function of directing and coordinating authority on national health work. They also undertook to mobilize all possible resources in their countries that could contribute to health development, including those of other relevant sectors and nongovernmental organizations.

11. The regional committees were accorded a more active part in the work of the Organization. They were urged to intensify their efforts to support the national strategies of the countries in the region as well as the regional and global strategies for health for all. To foster the unity of conception and action they were also urged 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. To this end they were requested to include the review of WHO's action in individual Member States within the region. But monitoring and control have to act in more than one direction. Just as the regional committees were urged to intensify their monitoring function within the region, the Executive Board was authorized to strengthen its role in giving effect to the decisions and policies of the Health Assembly, and to monitor on behalf of the 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.

[1] See document WHA33/1980/REC/1, resolution WHA33.17 and Annex 3.

12. The Health Assembly also defined principles for the provision of support by the Secretariat. Thus, it requested the Director-General and the 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. The Director-General was requested 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. He was also requested to adapt accordingly the organizational structures and staffing of the regional offices and of headquarters.

13. Immediately following the Thirty-third World Health Assembly a plan of action was worked out for implementing the above-mentioned resolution, and work for putting it into effect was started forthwith. Although greatest attention was paid during 1980 to the two crucial matters of the strategies for health for all and the structures of WHO in the light of its most important functions, the ongoing activities of the Organization during 1980 were certainly not neglected. The report that follows, which lays greatest emphasis on activities that took place in Member States and in the WHO regions, highlighting matters of particular interest, bears ready witness to the intensity of these activities.

Policies for health

14. The main thrust of WHO's activities in 1980 was towards promoting national, regional and global strategies for the attainment of the main social target for the next two decades: "Health for all by the year 2000, or the attainment by all citizens of the world of a level of health that will permit them to lead a socially and economically productive life".

15. Almost all the countries of the world have collectively pledged themselves to strive to reach that target. During the year they were joined by Equatorial Guinea, Saint Lucia, San Marino and Zimbabwe, all of which became Members of the Organization, bringing the membership to 156 plus one Associate Member.

16. The Executive Board, the World Health Assembly and the regional committees engaged in vigorous discussion to formulate policies for health during 1980; Table 1 lists some programme and organizational topics considered by the Executive Board and the Health Assembly, and Table 2 lists some issues debated by the regional committees. Two themes were common to all meetings: formulating strategies for attaining health for all by the year 2000, and the study of WHO's structures in the light of its functions. In other words, all of WHO's deliberating organs were examining how the Organization's principal objective can be achieved, and how WHO needs to be remodelled in order to contribute to achieving the objective most efficiently. These two themes and some of the other issues are covered in later sections of this report.

17. The subject chosen for the Technical Discussions at the Health Assembly in May was "The contribution of health to the New International Economic Order". The following were some of the points raised:

- There is a need for a complete and harmonious integration of the health sector into the overall development process, at the national as well as the international level; efforts to bring about such integration should be directed towards the goal of health for all by the year 2000 and based on primary health care and the Declaration of Alma-Ata.

- The health sector must be seen as a basic element in a country's socioeconomic development; also the health sector must allow for the participation of all peoples in the formulation and implementation of its plans.

- An essential prerequisite for the establishment of the New International Economic Order is strong political will and commitment at the national and international levels. The health sector can assist in this respect by helping to create the necessary political will and commitment within its own sphere of competence.

- Health must secure a more prominent role in the development process; this can partially be accomplished by creating a greater awareness amongst all national and international

planners of the important contribution which health has to make to socioeconomic development.

- The need for a new order is entirely justified given the many disturbances in the global economic situation. The New International Economic Order has provided WHO with a new optic for pushing ahead with social development, with a renewed emphasis on a just and equitable distribution of social goods and services, as implied in the Declaration of Alma-Ata. The health sector has a duty to state clearly (a) what resources it needs, given the overriding importance of health for each individual and each community; and (b) what the health sector can contribute towards economic growth and stability.

TABLE 1. SOME PROGRAMME AND ORGANIZATIONAL TOPICS CONSIDERED BY THE EXECUTIVE BOARD AND THE HEALTH ASSEMBLY DURING 1980[a]

Subject	Resolutions of the Executive Board (9-25 January)	Resolutions of the Health Assembly (5-23 May)
Formulating strategies for health for all by the year 2000: health as an integral part of development and of the New International Economic Order	EB65.R11	WHA33.24
Development and coordination of biomedical and health services research	-	WHA33.25
Workers' health programme	-	WHA33.31
Infant and young child feeding	-	WHA33.32
Action in respect of international conventions on narcotic and psychotropic substances: abuse of narcotic and psychotropic substances	EB65.R7	WHA33.27
Global smallpox eradication	EB65.R17	WHA33.3, WHA33.4
Tuberculosis control	-	WHA33.26
WHO's programme on smoking and health	-	WHA33.35
Strengthening WHO's health legislation programme	EB65.R13	WHA33.28
Study of WHO's structures in the light of its functions	EB65.R12	WHA33.17
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	EB65.R14	WHA33.20

[a] For the text of the resolutions mentioned, see WHO Handbook of Resolutions and Decisions, Vol. II (4th ed.), 1981.

TABLE 2. SOME ISSUES DEBATED BY THE REGIONAL COMMITTEES IN 1980[a]

Regional Committee for Africa (Brazzaville, 17-24 September)

- Primary health care
- Charter for the Health Development of the African Region
- Technical cooperation among developing countries
- National liberation and health
- Seventh General Programme of Work
- Development and coordination of research
- Prevention of blindness
- WHO's structures in the light of its functions
- Strategies for attaining health for all by the year 2000
- Information systems for the management of national health programmes[b]

Regional Committee for the Americas (Washington, DC, 22 September - 3 October)

- WHO's structures in the light of its functions
- Malaria control
- Women in development
- Strategies for attaining health for all by the year 2000
- Health assistance in disasters
- Community health education[b]

Regional Committee for South-East Asia (Malé, 1-7 September)

- Strategies for attaining health for all by the year 2000
- WHO's structures in the light of its functions
- International Drinking Water Supply and Sanitation Decade
- Health manpower planning and community participation for primary health care[b]

Regional Committee for Europe (Fez, Morocco, 7-11 October)

- Strategies for attaining health for all by the year 2000
- WHO's structures in the light of its functions
- Seventh General Programme of Work
- Problems of medical technology[b]

Regional Committee for the Western Pacific (Manila, 9-15 September)

- Strategies for attaining health for all by the year 2000
- WHO's structures in the light of its functions
- International Year of Disabled Persons
- Seventh General Programme of Work
- Disability prevention and rehabilitation
- Mental health
- Drug abuse
- International Drinking Water Supply and Sanitation Decade
- Programme of acute respiratory infections
- Development of the regional mental health programme
- Community involvement in health services development[b]

[a] There was no meeting of the Regional Committee for the Eastern Mediterranean during 1980.

[b] Subjects of technical discussions or presentations.

Strategies for attaining health for all by the year 2000

18. National, regional and global strategies for attaining health for all by the year 2000 need to be continuous, and should avoid inflexibility in formulation. Many countries developed their strategies during the year. The regional committees reviewed these strategies and proposed regional strategies based on them. Now WHO is developing a global strategy based on the national and regional strategies. It is applicable to all countries but particularly emphasizes the needs of developing countries, and is based on the individual and collective commitment of countries to attain the goal of health for all by the year 2000.

19. It has become clear that the attainment of that goal requires political, social and economic reforms, including a more equitable distribution of resources for health. Governments may wish to review their health systems regularly in the light of decisions taken collectively in WHO, to strengthen their ministries of health or equivalent bodies, and to provide the necessary mechanisms to ensure coordinated action on the part of all the sectors concerned. It is also evident that communities should be seriously involved in health work, and for this reason they need information, stimulation, advice and support; then they can participate, for instance, in the control of local endemic diseases.

20. The genuine partnership between WHO and its Member States is the key to attaining the common goal. One role of the Organization, for example, is to provide support in strengthening health infrastructures and in the training of health workers. Developments in the regions, described below, show the sort of action that can be taken.

21. The newly formed African Advisory Committee for Health Development reviewed the regional strategy for health for all. Most of the countries of the African Region have formulated realistic national strategies, and the regional strategy is a synthesis of the national strategies. Specific objectives were taken from the national strategies and classified into three groups: development of comprehensive health services, health science and technology, and promotion and support. There is an implementation schedule including objectives for 1990 related to immunization, water supply and sanitation, and the fight against hunger and malnutrition.

22. The strategy requires an additional US$ 2500 million per year (including US$ 2000 million for drinking-water and sanitation, US$ 55 million for the expanded programme on immunization, and US$ 25 million for malaria control) - US$ 7-10 per inhabitant per year - and extrabudgetary funding will be necessary. An African Regional Health 2000 Resources Group was therefore set up (see para. 30), and this group also met for the first time in June in Brazzaville.

23. The Regional Committee for Africa, meeting in September, considered the subject of strategies for attaining health for all. The Committee invited Member States to formulate detailed national plans of action with emphasis on primary health care, and to put their strategies into effect with the support of WHO, OAU and other organizations and institutions. The Regional Committee approved the regional strategy and requested the setting up of mechanisms to evaluate the progress of the work every two years and the impact of the work every six years.

24. In September the Regional Committee for the Americas considered the question of strategies for attaining the goal of health for all by the year 2000, together with the question of developments in the health sector in the decade 1971-1980 (the period covered by the Ten-Year Health Plan for the Americas). The Regional Committee agreed that primary health care and its components constitute the basic strategies for attaining the goal, and that they include: the extension of health service coverage and environmental improvement; community organization and participation; better mechanisms for intersectoral linkages; development of research and appropriate technologies; and the development of human resources. A regional plan of action is under preparation.

25. In June a regional meeting on strategies for health for all, jointly sponsored by WHO and UNICEF, was held at the WHO Regional Office for South-East Asia in New Delhi. The participants were senior officials from nine Member countries of the Region representing

health, planning, social welfare, rural and community development, and other disciplines. Members of an ad hoc subcommittee on research needs in this field, appointed by the ACMR, also attended. The meeting served as a forum for Member States to exchange information and experience relating to strategies for health for all, and to formulate regional strategies for collective action.

26. The European Region has a Regional Health Development Advisory Council, which advises on strategies for health for all. It is composed of members of the Consultative Group on Programme Development and experts from the Region in the fields of political science, economics and sociology. The Advisory Council proposed a comprehensive, coherent and consistent long-term strategy for the Region as a whole. In this strategy, three main programmes were identified: the promotion of lifestyles conducive to health; the reduction of preventable conditions; and the reorientation of the health care system. Of these, the first is the most important, the long-term aim being to encourage people to assume responsibility for their own health. When the Regional Committee discussed this question in October, it stressed the importance of indicators for monitoring the success of strategies; the general opinion was that the best course was to use few but accurate indicators, including some of a socioeconomic nature.

27. In the Eastern Mediterranean Region, following subregional meetings on health for all, held in Mogadishu (in February), Damascus (March) and Kuwait (April), draft regional strategies were formulated, based on the conclusions reached at the subregional meetings and on individual country strategy statements. Annexed to the draft was a proposal for the adoption by Member countries of an 11-point Charter for Health in the Eastern Mediterranean Region.

28. The Regional Committee for the Western Pacific unanimously adopted a regional strategy for attaining the goal of health for all by the year 2000, confident that this strategy would be strengthened as countries reached towards the goal through new knowledge and the application of existing knowledge. The strategy calls for three basic courses of action: laying the foundation for health (providing adequate food, water and shelter); developing individual and community self-reliance in health; and providing appropriate and affordable health technology for the sick, the disabled, the chronically ill and the socially maladjusted. The strategy focuses on primary health care as one of the principal approaches. The Regional Committee urged Member States to implement, monitor and evaluate their national strategies, reviewing them and updating them as required.

29. Of course, strategies require funding, and since funds originate from many sources and in many ways, it behoves WHO, in its international coordinating capacity, to foster mechanisms for the mobilization and rational channelling of funds. A new body, the Health 2000 Resources Group, since renamed the Health Resources Group for Primary Health Care, met for the first time in May and again in December. It is a mechanism established in accordance with resolution WHA29.32 for "attracting and coordinating an increased volume of bilateral and multilateral aid for health purposes". It is, as originally envisaged, a consultative group with an invited membership from bilateral, multilateral and nongovernmental agencies, with participation by developing countries, to advise the Director-General. The aim of the group is to promote rationalization of the flow of resources required for primary health care activities in developing countries and to stimulate the mobilization of new resources.

30. The African Region also has its Resources Group, already mentioned in paragraph 22. Technical cooperation among developing countries is being evolved in the Region, but funds are required to complement national efforts, particularly as regards countries whose currencies are not convertible. In view of their special needs, technical cooperation is being ensured with the national liberation movements recognized by OAU, particularly in relation to drug policies, and to priority programmes oriented towards 1990. In these endeavours the African Regional Health 2000 Resources Group has been working closely with the Regional Standing Committee on TCDC.

31. The Resources Group held its first meeting in Brazzaville in June. It includes representatives of Member countries, of organizations of the United Nations system, and of intergovernmental, governmental and nongovernmental organizations. Its terms of reference include advising on how best to secure extrabudgetary support, stimulating the mobilization of resources for health development, and promoting the exchange of information on health needs and resources.

32. The meeting urged contributors to focus their attention and financial support on the regional strategy for primary health care. The priority programmes identified as requiring extrabudgetary support in the African Region were: essential drugs (including the construction of pharmaceutical production plants, bulk purchasing, quality control, research on traditional medicine, training of personnel, and information exchange), malaria control (including the training of supervisory and operational staff, action on supplies and equipment, and technical cooperation between African countries and other developing and developed countries), immunization, and the provision of safe water supplies and sanitation.

33. In February there were meetings between senior officials from PAHO/WHO and from the Inter-American Development Bank, to continue discussions begun in 1979. They agreed that regular meetings should be held to work out ways of increasing collaboration between the two institutions. There was discussion of the implications that the goal of health for all by the year 2000 has for the Organization's programme of technical cooperation and the kinds of loans that the Bank makes to its member countries. The Bank participants agreed that priority attention must be given to primary health care and the extension of health service coverage, and requested the involvement of PAHO/WHO in the early stages of health-related projects.

Political support for health for all strategy

34. On 29 November 1979 the United Nations General Assembly, during an examination of long-term trends in economic development and of the working out of the New International Economic Order, unanimously adopted resolution 34/58 entitled "Health as an integral part of development". In adopting this resolution, the General Assembly recognized the vital role that health and health care play in the development of countries; fully endorsed the Declaration of Alma-Ata, and in particular its emphasis on primary health care; and approved the reorientation of WHO's activities towards the achievement of health for all by the year 2000. In May the World Health Assembly warmly welcomed this resolution.

35. What are the implications of resolution 34/58? It has implications for WHO, which should strengthen its commitment to its current objectives and elaborate appropriate strategies, keeping the General Assembly, through the Economic and Social Council, informed of its efforts in that direction. It has implications for the relevant bodies of the United Nations system, which should coordinate with and support the efforts of WHO. And, not least, it has implications for Member States, which should implement the Declaration of Alma-Ata and give full support to strategies for achieving an acceptable level of health for all.

36. Political support is an essential prerequisite for implementing the strategy for health for all. Such support needs to be actively sought and promoted. One source of political support can be geopolitical groupings of countries. An example is the OAU; WHO is inviting the OAU to include health for all by the year 2000 as an agenda item at one of its forthcoming summit meetings.

37. Another example is the Association of South-East Asian Nations. The cooperative spirit characteristic of ASEAN has permeated the health sector and reinforced international health cooperation, particularly with WHO. A meeting of ASEAN Health Ministers (from Indonesia, Malaysia, Philippines, Singapore and Thailand) held in Manila in July accepted among the regional priorities WHO's goal of health for all by the year 2000 through primary health care. The Ministers signed a Declaration of Collaboration in Health in which they declared "their agreement to strengthen and coordinate regional collaboration in health among ASEAN countries". They adopted the following guidelines:

- ensure that collaboration contributes directly or indirectly towards regional self-reliance and self-determination;
- emphasize health as an integral part of overall socioeconomic development;
- aim at making health care accessible to the total population, with priority being given to the underserved and depressed areas;
- promote health manpower development consistent with the needs of the ASEAN member countries;

- continue with international collaboration in health while striving to be self-reliant in the delivery of health services;

- emphasize primary health care in the overall development strategy.

38. The Ministers also declared that the programme areas of technical collaboration among their countries should include: primary health care; disease control; health planning, management and information systems; nutrition; health manpower development; environmental and occupational health; pharmaceuticals, biologicals and traditional medicine; and mental health. They agreed to develop a formal mechanism within the ASEAN structure to facilitate effective collaboration in these areas.

39. A third example is the movement of non-aligned countries. In May, the Fourth Meeting of Ministers of Health of the Non-Aligned Countries and Other Developing Countries discussed several aspects of WHO's goal of health for all by the year 2000. The meeting adopted a resolution supporting the goal and calling on all countries in the movement to develop an appropriate programme of action. The Ministers agreed to use the mechanisms of WHO to:

- engage in bilateral and multilateral exchanges of the experience obtained in this direction;

- exchange information;

- request or send consultants and advisers, in line with each country's possibilities;

- coordinate research projects in biomedical and health matters; and

- request or offer material, technical, human and financial support for implementing the priorities of the programme of action adopted at the Sixth Conference of Heads of State or Government of Non-Aligned Countries in line with possibilities and needs.

40. The adoption of regional charters for health development is a welcome phenomenon, indicative of widespread political support for WHO's policies and acceptance of the concept of technical cooperation. The official signing by certain countries of the Charter for the Health Development of the African Region was a milestone of major importance. It marked a decisive step in reaffirming Member States' individual and collective determination to attain a reasonable level of health. The objectives of the Charter include improvement of the levels of health in the agreed priorities of primary health care, manpower development and training, provision of safe water and sanitation, promotion of maternal and child health, and control of communicable diseases. The Charter affirms the commitment of Member States in areas which they jointly consider to be important for health development. By collectively binding governments to common ideals which they already hold individually, the Charter can be an effective instrument for achieving peace, progress and cooperation.

41. During the year Sri Lanka, Thailand, Bangladesh, India (in February), Indonesia (April), Mongolia, Democratic People's Republic of Korea (July), Nepal and Maldives (August) signed the Asian Charter for Health Development. The Charter is a means for the countries of the Region to cooperate in building up individual self-reliance and collective self-sufficiency. It aims to promote intercountry consultation and collaboration and to foster close international cooperation, providing a common basis for formulating health plans, programmes and projects in the best way possible, within the framework of national, regional and global development policies.

WHO's structures in the light of its functions

42. In addition to funding, strategies need smoothly-running mechanisms to put them into operation: the structure of WHO must be appropriate to the work it has to carry out. Having reviewed the Executive Board's study on the subject of WHO's structures in the light of its functions, the World Health Assembly in May decided that WHO should concentrate its activities on support to strategies for attaining health for all, and that it should take action for health in addition to indicating how such action might be carried out. The Assembly felt

that the functions of the regional offices and WHO headquarters should be redefined, and organizational structures and staffing adapted, so as to ensure the provision of adequate and consistent support to Member States. The engagement of national staff and of international WHO field staff should be reviewed, to ensure the full involvement of both kinds of staff in collaborative national programmes.

43. The Health Assembly considered that the Executive Board should strengthen its role in giving effect to the decisions and policies of the Health Assembly and in advising the Assembly; become increasingly active in presenting major issues to the Assembly; and correlate its own work with that of the Assembly and the regional committees, monitoring the way in which the regional committees reflect the Assembly's policies in their work.

44. The regional committees, in the view of the Health Assembly, should intensify their efforts in developing regional health policies and programmes in support of health for all, support technical cooperation among all Member States, support the establishment or strengthening of multisectoral national health councils, and increase their monitoring, control and evaluation activities.

45. The Health Assembly did not omit to indicate what the Member States themselves should be doing. They should review the role of their ministries of health, establish multisectoral national health councils, and mobilize all possible resources that could contribute to health development. In addition, they should improve their coordinating mechanisms in support of their health development strategy and technical cooperation, and cooordinate their representation within WHO and in the United Nations and its specialized agencies concerned with development.

46. If the instructions of the Health Assembly are faithfully followed - difficult though that may be in many cases - there is no doubt that Member States and their Organization will be in a much better position to cooperate with each other in progressing towards the long-term goal that they have set themselves.

47. WHO's moves in this direction include the more widespread use of nationals and collaborating centres. The African Region, for instance, now has 11 WHO programme coordinators who are nationals, i.e., nearly one-third of the total. As expected, they are making a valuable contribution: frequently they are members of national delegations to the Organization's governing bodies, and they have free access to political leaders and participate in national structures. They therefore facilitate technical cooperation.

48. In the South-East Asia Region too, there has been greater involvement of nationals in WHO's work. Since 1976 nationals have been appointed to carry out various project assignments in six countries of the Region, and contractual service agreements have been signed during this period with over 70 individuals, more than 20 of whom were national project managers or project staff recruited to assist specifically with the technical and administrative development of a particular project or national activity. The experience so far with these arrangements, which encourage national self-reliance and make use of national expertise, has been extremely satisfactory and has highlighted the need to pursue the employment of national project staff under suitable agreements that retain as much flexibility in their employment as possible.

49. WHO has increased the number of its regional collaborating centres in the South-East Asia Region. Efforts have been made to identify and designate collaborating centres for undertaking specific activities under the regional research plans in the following subjects: health services research, nutrition, liver diseases including liver cancer, and mental health. These are in addition to existing WHO collaborating centres. An inventory of national centres of excellence in various fields is being compiled and appropriate institutions are being identified for designation as WHO-recognized centres.

Launching the Water Decade

50. The great potential of inter-agency and international action for promoting change will become evident during the International Drinking Water Supply and Sanitation Decade (1981-1990). On 10 November the Decade was launched at a special meeting of the United Nations

General Assembly. It is estimated that about 80% of all disease in developing countries is related to an unsafe water supply and sanitation, and well over 1000 million people lack adequate amenities. To remedy this situation, the organizations within the United Nations system concerned with this field (United Nations, UNICEF, UNDP, ILO, FAO, World Bank, WHO) are pursuing a collaborative approach during the Decade, based on encouraging self-reliance by the developing countries, with the focus on community involvement and participation. The aim is to achieve maximum benefit for the rural and urban poor.

51. The overall strategy has six major objectives:

- to support governments in developing and carrying out their strategies;
- to promote a sense of responsibility and self-reliance at the community level, particularly through educating people about water, health and disease;
- to support the institutional development required in countries;
- to ensure the training of the manpower required at all levels;
- to help develop practical, low-cost technologies supported by exchange of information and expertise;
- to mobilize additional resources and rationalize their international transfer.

52. Although the Decade will require on average an estimated annual investment totalling about US$ 30 000 million, the potential benefits will be many times more than that in terms of social and economic progress. External contributors include the World Bank, several regional development banks, the agencies of the Organization of the Petroleum Exporting Countries (OPEC), the cooperating organizations of the United Nations system, and nongovernmental organizations.

53. WHO has global technical responsibility for the Decade and also acts as the secretariat to the United Nations Steering Committee for the Decade, composed of representatives of the seven agencies mentioned above. The strength of WHO's participation in the Decade resides in the Organization's technical cooperation at the country level. For the biennium 1980-1981 some 150 projects of technical cooperation are provided for in 93 countries, and the long-standing involvement of the Organization in this type of work is the basis of WHO's expertise. No other international agency has so much experience in national planning for water supply and sanitation.

Technical cooperation

54. During 1980 the Executive Board and regional committees reviewed the subject of technical cooperation. There was general agreement that WHO's technical cooperation and coordinating functions are mutually reinforcing aspects of the Organization's international health work. This work should not be fragmented; it should be pursued by Member States individually and collectively as envisaged in the Constitution, "for the purpose of cooperation among themselves and with others to promote and protect the health of all peoples". The days of "technical assistance" are well and truly over. That concept has given way to "technical cooperation", which was described as "joint action of Member States cooperating among themselves or between them and WHO, directed to the attainment of the main goal of the Organization as stated in the Constitution, resolution WHA30.43 and other Health Assembly resolutions, as well as the Declaration of Alma-Ata".

55. The new concept implies equality of the cooperating parties, sovereignty and responsibility of each side for a more rational use of all forms of cooperation, and mutual responsibility for the achievement of goals, exchange of information and experience, and evaluation of results. The "donor" and "recipient" relationships of technical assistance are no longer valid. While it is helpful to classify technical cooperation into four types (between WHO and Member States; among developing countries - i.e., TCDC; among developed countries; and between developed and developing countries), they should be viewed as an organic whole, with WHO exercising a leadership role and a coordinating function.

56. Some examples illustrate both the combination of WHO's coordinating and technical cooperation functions and the mutual support of research and technical cooperation:

- In the campaign to eradicate smallpox (see also para. 68), WHO coordinated the development of policies, principles, and scientific and technical bases, which were applied in the Organization's technical cooperation with individual countries. This technical cooperation in turn stimulated improvements in methods which were universally disseminated through WHO's coordinating information exchange function.

- In the Special Programme of Research, Development and Research Training in Human Reproduction (see also para. 101), the management of research is carried out on a cooperative basis, and the research itself - for instance, research carried out on intrauterine contraceptive devices - is pursued on a collaborative basis, both "horizontal" (institutions of different countries working together) and "vertical" (scientists in various countries attacking different aspects of a common problem, in accordance with a defined strategy).

- Malaria research is dealt with jointly by the UNDP/World Bank/WHO Special Programme of Research and Training in Tropical Diseases (see also para. 174) and WHO's Malaria Action Programme (see also para. 133). The research undertaken - for instance, research on the resistance of Plasmodium falciparum to chloroquine and other 4-aminoquinolines - is, as in the case of the other illustrations mentioned above, agreed upon and conducted as an international collaborative effort within WHO's coordinating function. The Organization stimulates the scientific community, in both developed and developing countries, to tackle problems identified in the countries themselves, and ensures that the findings are disseminated worldwide so that they can be utilized wherever they are needed. Thus, WHO's research, information and technology transfer, and operational functions are closely interlinked and mutually supportive.

57. The African Region has a Standing Committee on Technical Cooperation among Developing Countries. In the view of the Standing Committee, experience with bilateral and multilateral technical cooperation has highlighted the need for a multisectoral approach. In 1980 it recommended a coordinated system for the group purchasing of drugs and for the development of a pharmaceutical industry and of a traditional pharmacopoiea. The Standing Committee felt that the regional structures for implementing TCDC were satisfactory: subregional working groups, regional expert panels, collaborating centres and intercountry projects. It considered that the development of a regional network of national health development centres should further stimulate technical cooperation among developing countries.

58. This subject was to the fore in the discussions of the Regional Committee for Africa. The Regional Committee invited Member States to ensure that health is given its rightful place in any agreement on technical cooperation, and to strengthen the role of health ministries in all multisectoral mechanisms for promoting technical cooperation, and especially among developing countries. The Regional Committee wished the World Health Assembly to consider proposals for increasing the voluntary contributions to the African Region in order to implement primary health care, support national liberation movements recognized by OAU, deal with the consequences of disasters and natural catastrophes, and promote biomedical and health services research.

Research promotion and development

59. Health services and technology cannot make progress without research, and the research needs to be relevant to overall objectives rather than an end in itself. Research also needs adequate institutions, facilities, personnel, training arrangements and funding. To oversee its activities in this field, WHO has a global Advisory Committee on Medical Research (ACMR) and six regional ACMRs.

60. The World Health Assembly reaffirmed in May that biomedical, health services and health promotion research should contribute in a major way to progress towards health for all by the year 2000. It urged Member States to intensify their cooperation in health research and to give high priority to research training and institution strengthening.

61. The twenty-second session of the global ACMR was held in Geneva in October. The Committee reviewed progress made in current WHO research efforts, including the special programmes on research and training; it also discussed reports of action taken on suggestions and recommendations made by ACMR at its previous session, especially on the topics of nutrition, control of diarrhoeal diseases, and ethical review procedures for research involving human subjects. ACMR reviewed the work of its subcommittees on information, health services research, research on mental health and human behaviour in primary health care, research administration, and research career structures. It recommended that the subcommittees on information and on research administration should continue their work; that a subcommittee be established to study the research component of the WHO cancer programme; that the subcommittee on health services research, following its session in November 1980, be transformed into a scientific planning group; and that scientific planning groups be established for the programmes in nutrition and in mental health and human behaviour in primary health care.

62. When reviewing the activities of the regional ACMRs (the important issues that they discussed are listed in Table 3), the global ACMR noted that one of the main constraints preventing effective action by some regional ACMRs was lack of funds, and proposed that all regional offices should earmark a minimum of 5% of their regional budgets for research. There was a wide disparity between the capabilities of the various regions and between countries in the regions, which also prevented some regional ACMRs from achieving their objectives of instituting relevant country-based studies.

63. In the view of ACMR, the practical implementation of relevant research programmes at country level depended not only on the availability of resources but also on effective communication. It suggested that efforts should be made to achieve better interdigitation between national research priorities and those of WHO at regional and global levels. Certain projects could be funded partly by WHO and partly by Member States, while others could usefully benefit from experience acquired at interregional level.

64. ACMR also discussed research career structures, including a recommendation that, rather than promote research career structures per se, WHO should support research activities as a basic component of health plans and programmes. In the discussion, it was stressed that the problem of research opportunities and research career structures was essentially a national one and that careers in research could not be viewed separately from careers in other government services and institutions. The general view was that appropriate systems of peer approval and provision of opportunities for young scientists to interact with colleagues were stimuli to research workers.

65. In 1980 a subcommittee of the South-East Asia Regional ACMR was set up to review research priorities and identify research needs in relation to the goal of health for all by the year 2000 with primary health care as the key approach. In November a consultative meeting was held in New Delhi on ways of encouraging health promotion research, and plans were made to develop social services research in relation to health. To further the implementation of the diarrhoeal diseases research programme, a scientific working group was set up in the Regional Office to consider operational research studies. Research methodology courses, both of a general nature and on specific subjects, were conducted in several countries of the Region with a view to developing research capability.

66. Under the auspices of the Eastern Mediterranean Regional ACMR a study was undertaken in Bahrain, Egypt and Yemen - due for completion in 1981 - on the perspectives and requirements for achieving effective health service coverage by the year 2000. The study is concerned with identifying what predicts whether or not a health service delivery system is a good one. In May-July, the Regional Office for the Eastern Mediterranean, in collaboration with the University of Nottingham, United Kingdom, organized a course in Nottingham on community medicine and health services research. In September the Regional Office convened a consultation on research management.

67. In October the Regional Office for the Western Pacific organized a national workshop on health service research at the Korean Health Development Institute, Republic of Korea.

TABLE 3. IMPORTANT ISSUES DISCUSSED BY THE REGIONAL ADVISORY COMMITTEES ON MEDICAL RESEARCH

African Region
Nutrition, including investigations of contamination of foodstuffs, especially by mycotoxins
Diarrhoeal diseases
Health services research, with particular reference to human reproduction
Communicable diseases research
Epidemiological research
Region of the Americas
Diarrhoeal diseases, including use of oral rehydration
Health services research, with particular reference to social science and operational research
Ethical review of investigations involving human subjects
Malaria control
Health information systems
South-East Asia Region
Action-oriented research in nutrition and diarrhoeal diseases
Elaboration of ethical review mechanisms
Promotion of special programmes of research in tropical diseases and human reproduction
Establishment of networks of collaborating centres
European Region
Evaluation of drugs
Health care delivery, with special reference to the control of hypertension
Health services research
Economic aspects of primary health care
Eastern Mediterranean Region
Health services research
Promotion of primary health care
Liver diseases
Malaria
Diarrhoeal diseases
Western Pacific Region
Serology of parasitic diseases
Cardiovascular diseases
Diarrhoeal diseases
Acute respiratory infections
Biomedical research methodology

Global eradication of smallpox

68. The story of smallpox eradication provides a shining example of how the countries of the world can work together in research and in action to combat a menace to health. The last case of endemic smallpox occurred in Somalia in October 1977. Continuing surveillance in the Horn of Africa and elsewhere in the world has confirmed that the world has been free from endemic smallpox for the last three years.

69. On 8 May 1980 the World Health Assembly proclaimed the global eradication of smallpox and adopted a resolution expressing its deep gratitude to all nations and individuals who had contributed to the success of this programme, calling the attention of all nations to this unprecedented achievement in the history of public health, which demonstrates how nations working together may change the world for the better, creating a hopeful new impetus towards health for all by the year 2000. The proclamation was based on the report of the Global Commission for the Certification of Smallpox Eradication, an independent body of 21 experts from 19 countries who evaluated the evidence that eradication of smallpox had been attained throughout the world.

70. The Health Assembly adopted the recommendations of the Global Commission concerning future policies and further research designed to ensure permanent freedom from the disease. The Commission concluded that smallpox vaccination is no longer justified except for investigators at special risk and that international certificates of vaccination against smallpox are no longer required. But it stressed that vaccine stocks sufficient to immunize 200 million people should be maintained and regularly tested for potency. Suspected cases of smallpox will continue to be reported and all such reports should be thoroughly investigated. A special surveillance and research programme on human monkeypox and other important orthopoxvirus infections should be continued. Adequate security and control should be maintained in laboratories retaining stocks of variola virus.

71. The Global Commission concluded that monkeypox virus does not constitute a threat to the permanence of smallpox eradication, but recommended that research and surveillance should continue. The collection of material for laboratory investigation, as well as information aimed at determining the natural reservoir of monkeypox, continued throughout 1980. Although monkeypox-specific antibodies have been found in sera of some non-human primates, the natural reservoir of the virus remains unknown, so research is continuing. A workshop to develop a surveillance system for monkeypox and haemorrhagic fevers was conducted in Brazzaville in April-May 1980, in which scientists from 13 African countries participated. Laboratory studies on the genetic structure of orthopoxviruses are also continuing.

72. During 1980, 26 rumours of smallpox were investigated either by WHO, by national authorities or by joint WHO/national teams in various parts of the world. The results of the investigations, which showed that none of the reports were due to smallpox, reinforce the credibility of global eradication. At the end of 1980, six laboratories retained stocks of variola virus: one each in China, the Netherlands, South Africa, the United Kingdom, the United States of America and the USSR. All were inspected by WHO teams, and safe measures for storing or working with variola virus were ensured. At the end of the year, a total of 66 million doses of vaccine were being stored in WHO repositories in Geneva and New Delhi, and donations exceeding 35 million doses were outstanding from pledges. There were also at least 102 million doses in national vaccine reserves of 30 individual countries. Smallpox vaccination was no longer obligatory in 78 countries. An international certificate of vaccination against smallpox was still required by Chad and Democratic Kampuchea.

World Health Day

73. Whereas smallpox has been eliminated through international and national action, there are some health problems, such as smoking, that need something in addition, namely action or decisions on the part of individuals. Indeed, the goal of health for all by the year 2000 will never be achieved unless communities and individuals become fully health conscious, that is, become aware of obstacles to health and how those obstacles can be overcome. Individuals need to be encouraged to adopt healthy lifestyles with regard, for instance, to smoking, alcohol consumption, and the excessive use of drugs, for medical or other reasons. Such encouragement in respect of smoking was offered by World Health Day, 1980.

74. The theme of World Health Day (7 April) was "Smoking or health - the choice is yours". WHO's information kits and a documentary film exposed the strategies adopted by the tobacco industry to transfer high-pressure sales techniques to developing countries (there is some parallel with the activities of the drug and infant formula industries in this respect), as sales have levelled off in developed countries. UNCTAD estimates that the industry spends US$ 2000 million per annum on cigarette advertising and promotion.

75. Following WHO's lead, many Member States began aggressive national education campaigns - frequently for the first time, and often supported by nongovernmental organizations and civic groups - and awareness of the man-made smoking epidemic spread worldwide. A number of governments responded to the heightened public awareness of the problem by launching programmes and introducing legal and administrative curbs on smoking. These measures dealt particularly with the production, advertising, promotion and sales of cigarettes. Information reaching WHO from many sources confirmed that the theme of World Health Day 1980 was a decisive spur to action. The Appendix to this report gives details of selected measures in various countries, and shows the remarkable extent to which countries responded to the call of World Health Day.

Development of comprehensive health services

76. If the Organization's objectives are to be achieved, every country in the world must now take steps to provide primary health care accessible to all its population, shifting resources and decision-making powers from the centre to the periphery, and devoting less of the health budget to costly, sophisticated, irrelevant technology and more to appropriate technology and preventive and health-promoting behaviour programmes. In 1980, WHO's endeavours in promoting the development of comprehensive health services were largely directed to such ends.

77. Primary health care. During the year the countries of the African Region showed a growing interest in primary health care. In collaboration with WHO, several countries (including Benin, Burundi, Congo, Gambia, United Republic of Tanzania, Upper Volta and Zambia) formulated their national action programmes for primary health care, and several others were in the process of doing so. These programmes take into account the national resources involved and the external contributions required.

78. In the Region of the Americas, much emphasis was placed during 1980 on the promotion of technical cooperation activities in primary health care. Costa Rica, Jamaica, Mexico and Peru were particularly active, developing comprehensive projects in this area. The Andean Region group of countries participated in a major subregional undertaking on the programming, development and maintenance of health care facilities as a component of the extension of health services coverage; this undertaking involves technical cooperation in programme development at the national and subregional levels.

79. In October, the Regional Office for South-East Asia convened an expert group meeting on teamwork and its role in the provision of primary health care. The participants were WHO staff members and national colleagues involved in health teams and teamwork, planning, implementation and evaluation. The meeting examined the main issues likely to promote the development of teamwork in primary health care services, the various existing models and their possible application in the Region. The aim of the meeting was to enable the Regional Office to offer Member States recommendations concerning the elaboration of national policies for the coordination and strengthening of primary health care resources and activities. Further meetings will follow at country level to work out details of training programmes for teamwork and the allocation of tasks to specific members of each health care team.

80. In the Eastern Mediterranean Region, Democratic Yemen, Pakistan and Yemen completed the formulation of comprehensive primary health care programmes and took the initial steps in their implementation. Somalia and Sudan put their primary health care programmes into operation. UNICEF and WHO are fully involved in the programme in Somalia, which includes the training of large numbers of primary health workers recruited in the communities that they will serve. Community acceptance of the programme supported by the African Development Bank and UNICEF in Sudan was demonstrated by local willingness to construct and equip the new primary health care units.

81. In the Western Pacific Region, a national workshop on primary health care was held in the Trust Territory of the Pacific Islands. In the Philippines, the primary health care research project at Tacloban, Leyte, became part of a wider process to improve the health care delivery in one region of the country. WHO collaborated with the Government of the Philippines and with ESCAP in an integrated rural development project in Pangasinan Province. National workshops on the nursing aspect of primary health care took place in Papua New Guinea, the Philippines and the Republic of Korea. Training courses in primary health care started in China; three of these courses were held in 1980 at primary health care centres located in three rural counties being used as pilot areas for such training.

82. A major concern of WHO and UNICEF has been how the principles of primary health care were being put into practice, the constraints and obstacles to the formulation of national policies, strategies and plans, and the means for overcoming them. In 1979-1980 UNICEF and WHO undertook a joint study to elucidate these critical issues. This study, entitled "Country decision-making for the achievement of the objective of primary health care", was of direct use to the participating countries (Burma, Costa Rica, Democratic Yemen, Finland, Mali, Mozambique and Papua New Guinea) individually and as a means of exchanging experiences; in addition, it will be of use to the international community as a whole. In October, a meeting of the principal investigators and others consolidated and synthesized the country experiences. In several of the countries the process of carrying out the study had a useful promotional effect and made an impact on the way in which policy decisions were made.

83. Means used to further national policies, strategies and plans included numerous interregional, regional, intercountry and national workshops and seminars held with the aim of mobilizing staff. Perhaps of greater consequence were the preparatory and post-workshop activities undertaken in the individual countries by teams comprising representatives of the health sector and other sectors such as education, agriculture, public works and information. UNICEF representatives and WHO programme coordinators were active in promoting this multisectoral collaboration, and the staff of the two organizations often participated in the country teams. Technical modules were developed to help country teams address various issues and also to provide them with information that might be useful in activities prior to workshops, during the workshops themselves, and in the follow-up activities in countries.

84. One workshop of this kind was the joint UNICEF/WHO workshop on primary health care that was held in March at Nampula, Mozambique, for English-speaking participants. It was attended by nationals from the health sectors in Botswana, Ethiopia, Gambia, Lesotho, Mozambique, Nigeria, Swaziland, Uganda and the United Republic of Tanzania. The main aim of the workshop was to develop in the countries a common understanding of the concept and activities of primary health care, to study the possible points of entry for introducing primary health care into other development activities, and to promote collaboration at country level among the various sectors and agencies involved in planning for primary health care. One important product of the workshop was a set of recommendations on priorities, strategies and feasibility, multisectoral coordination, indicators and TCDC.

85. In February, a UNICEF/WHO interregional workshop on the community health worker took place in Kingston, Jamaica. The workshop was part of a study: nearly a year previously, a background document containing a set of 15 issues and questions was sent to principal investigators in 13 countries in all the WHO regions. An analysis of the responses, carried out by the participants themselves, served as the basis of the workshop, attended by the principal investigators. The outcome was twofold: a set of recommendations based on agreed principles relating to the selection, training, functioning and support of community health workers; and follow-up activities in connexion with further in-depth study or the gathering of additional information on this important topic.

86. An interregional workshop on primary health care, supported by UNICEF and WHO, was held in Chiang Mai, Thailand, in June. Case studies of important primary health care projects in two countries of each of the two regions concerned (South-East Asia and Western Pacific) were discussed in the workshop as examples for sharing experience in the implementation of primary health care in developing countries.

87. WHO and UNICEF, in collaboration with other agencies in the United Nations system and intergovernmental and nongovernmental organizations, undertook activities relating to the

cost and financing of primary health care. With the cooperation of 16 participating countries in all the WHO regions, information was collected on country experience in this field. Following the country studies, an interregional workshop held in Geneva in December considered country reports that gave costings of the major components of primary health care programmes and schemes and described methods or patterns of financing. Quite apart from providing up-to-date information on the present situation and on countries' concern for the future, this activity had a catalytic effect, mobilizing financial and technical support from international and regional agencies and nongovernmental organizations.

88. Over a period of 18 months, information was gathered on national experiences of malaria control as a constituent of primary health care, particularly in China, Costa Rica, Cuba, India, Thailand and Viet Nam. An informal meeting on this topic was held in Washington, DC, in July, and a paper outlining the experiences of the six countries was presented at the Seventh Asian Malaria Conference in Manila in November. The experiences demonstrate the possibility of integrating malaria control into the health system under a variety of political, economic, epidemiological, social and cultural conditions. It was shown that the effective planning, implementation and evaluation of malaria control activities within the framework of primary health care requires a nucleus of malaria experts with the ability to determine malaria strategies in keeping with local conditions as well as political and economic factors; this nucleus must be linked with the health services system.

89. Interagency action for rural development was undertaken. WHO pursued its collaboration with the ACC Task Force on Rural Development, including participation in a five-country evaluation study. This is a continuing activity aimed at strengthening a collaborative approach to rural development among agencies, particularly at the country level. During 1980 the focus was on the reassessment of joint activities with a proposal for a programme of work based on the reassessment and on an agreed plan of action for agrarian reform and rural development.

90. WHO's policies regarding health care are not only applicable to developing countries: they are equally relevant to conditions in the developed countries. Politicians, health administrators and others in some of the richer countries of the world are now realizing the impossibility of meeting the spiralling costs of health technology and are seeking more rational ways of using resources to provide health care for the people. In the European Region, WHO is maintaining close contact with the Italian health authorities during the implementation of the National Health Service Law, in order to facilitate the exchange of experience between Italy and other countries. The new national health service, based on the national health plan for 1980-1982, came into operation on 1 January 1980.

91. The overall objectives of the Italian plan are to improve the health care provided, to contain costs, and to reduce the differences in health resources and coverage among the regions. The service is financed by a national fund for health, based on the contributions which the population has hitherto made to the various health insurance systems. The Bank of Italy has a role in managing the national fund. The distribution of the financial resources among the different regions is based on the size of the population and local health indicators relating to children, workers, and old people. Equity among the regions will be achieved by stages over six years. The setting of priorities contributes to the attainment of equity by facilitating greater efficiency in the regions, thus liberating resources that can be assigned to less favoured areas and groups. The changes initiated in Italy take into account various themes advocated by WHO: primary health care, community participation, intersectoral cooperation, decentralization and regional equity.

92. During the session of the Regional Committee for Europe in October, technical discussions were held on "The problems of medical technology", with particular reference to the development, assessment and utilization of medical technologies; education and training; professional and public attitudes; and future trends in technology in the context of health for all by the year 2000. Various views were put forward on the value of centralized as opposed to regionalized technology assessment procedures. It was stressed that each country would have to choose assessment measures closely adapted to its own health care system. It was also apparent that the question of cost would have to be closely investigated in relation to functions. The conclusions reached at the discussions included the following:

- It is essential to develop national medical technology policies.

- There is a clear need for national or regional centres which would undertake comprehensive assessments of medical technology, including analyses of safety and efficacy, as well as economic, social and ethical issues.

- Cost-effectiveness and cost-benefit analyses of current and developing medical technologies are worthwhile and should be supported, and above all a concept of general cost-consciousness should be developed in all parties concerned.

- The results of assessments should be disseminated to the practising and scientific communities and others concerned.

- Utilization studies should be conducted and adverse effects be reported.

- Adequate graduate, postgraduate and continuing education of all those involved (physicians, scientists, technicians and other health care personnel) should be planned and implemented.

- Balanced information should be provided to the public.

- WHO should coordinate the activities of national assessment networks and, whenever possible, also act as a clearing-house for information on medical technology.

93. Maternal and child health. In the Region of the Americas, under an agreement between PAHO/WHO and the W. K. Kellogg Foundation, the Organization began in 1980 coordinating and participating in a major maternal and child health programme financed in part by the Foundation (to the extent of US$ 4.1 million). Through the three-year programme (1980-1982) PAHO/WHO is seeking to develop an expanded network of family health projects in Latin America. The aim is to increase and improve the coverage of services, extending them to underserved populations. The PAHO Latin American Center for Perinatology and Human Development, located in Montevideo, will be deeply involved in the programme; it will develop models for maternal and child health care in two states of Uruguay, utilizing advances in appropriate technology developed by the Center. A second part of the programme will deal with the dissemination of scientific information and the production of education materials. A third part will involve the creation of a network of national subprojects combining the provision of services, teaching, and research in maternal and child health. The programme is an enlargement of a joint programme begun with the Foundation in 1974 in Brazil and Colombia.

94. In the Eastern Mediterranean Region, the maternal, child and family health project jointly sponsored in Somalia by UNFPA and WHO made such good progress in the project area that it was decided to extend it to the whole country. The project area includes the city of Mogadishu, three agricultural and seminomadic districts and a resettlement area with a total population estimated in 1979 to be about 700 000. From January 1979 to August 1980, the number of maternal and child health centres in this area increased from 13 to 20 and the number of public health nurses/midwives from 33 to 52. Five of the seven new centres were started in villages and nomadic areas and five of them were built by the community. The furniture for the rural units was also provided by the community. Home visiting by public health nurses/midwives has been greatly increased, and families are encouraged to approach the centres for treatment in case of sickness. By the end of 1980, about 10 000 families had been registered for integrated care, and some 90% of the children in these families had been immunized. Integration of health services is gaining momentum. All registered pregnant and nursing women and severely and moderately malnourished children are given food supplements provided by WFP. Nurses organize nutrition demonstrations and give talks on health and nutrition at orientation centres. Health education has also become a regular feature of life.

95. In the Western Pacific Region, a WHO working group met in Manila in March to discuss and recommend programmes for bringing about improvements in the health care of adolescents. Experts from 10 countries (Australia, China, Japan, Malaysia, New Zealand, Papua New Guinea, Philippines, Republic of Korea, Singapore and Viet Nam) also identified the types of research, training and service intervention for meeting these health needs. The importance of

adolescents in terms of physical, psychological, economic, social and political factors was stressed. In urbanizing societies, they constitute a specific group with certain identifiable characteristics, needs and problems. Psychologically, adolescence represents the most vulnerable phase of the life cycle. The stress of rapid technological development and social change must be held largely responsible for the alarming increases in accidents, drug and alcohol abuse, sexually transmitted disease and unwanted pregnancies, psychological problems and suicide among young people. It was acknowledged that adolescence represents the last great chance for change, and provides a golden opportunity to set things right, to practise preventive care and thus influence the health and well-being of adults in the future. Less research had been undertaken on this age-group compared with other age-groups and little teaching had been provided in relation to the needs and problems of adolescents. The working group formulated recommendations to WHO and to governments on this subject.

96. In May the World Health Assembly endorsed in their entirety the statement and recommendations made by the joint WHO/UNICEF Meeting on Infant and Young Child Feeding, held in Geneva in the previous October. These included the encouragement and support of breastfeeding; the promotion and support of appropriate weaning practices; the strengthening of education, training and 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.

97. During 1980 WHO intensified its activities for promoting the application of these recommendations, and specific global and regional plans were made. For example, a three-year programme was developed in the African Region (already operative in Angola, Ethiopia, Madagascar, Nigeria, Senegal and Sierra Leone) for collaboration in national activities with the aim of improving maternal nutrition, safeguarding breastfeeding, and ensuring the better use of local foods during the weaning period. A national workshop on the status of women and their role in improving child care, especially breastfeeding, was held in July in Ghana, with the collaboration of the Ministry of Health and the United Nations University. In the Region of the Americas, national and subregional workshops were held on the subject of breastfeeding. In the European Region, WHO continued to collaborate with the Swedish National Board of Welfare, and a task force was established in Sweden to examine the question of guidelines for the export of infant foods, and infant food technology. In the Eastern Mediterranean Region, UNICEF supported studies on infant feeding practices in the Gulf States, and WHO laid stress on the importance of breastfeeding as part of ongoing maternal and child health activities. In the Western Pacific Region, a national workshop held in Hong Kong in June resulted in the setting up of a task force. Other workshops were held on the occasion of international and regional professional conferences. WHO completed the first phase of its collaborative study on the prevalence and duration of breastfeeding.

98. The Organization participated in interagency bodies concerned with the promotion of adequate weaning. Activities related to weaning were developed as part of the action-oriented research, development and training programme in nutrition, focusing on meeting the nutritional needs of the young child through the use of locally available and acceptable foods.

99. One of the recommendations emerging from the joint WHO/UNICEF meeting was that there should be an international code of marketing of infant formula and other products used as breastmilk substitutes. WHO and UNICEF formulated a first draft of such a code and sent it to all Member States in February, with a request for comments and observations. Based on these comments and the outcome of a series of consultations with interested parties - governments, agencies of the United Nations system, nongovernmental organizations, the infant food industry, and experts - a second draft was prepared for the World Health Assembly in May. In compliance with the decisions and comments made in that forum, a third draft was prepared and discussed at two additional consultations, following which what is now known as the draft International Code of Marketing of Breastmilk Substitutes was elaborated for submission to the Executive Board and Health Assembly in 1981. The Code recommends action to govern the production, storage and distribution, as well as advertising, of infant feeding products. It calls for relevant information in infant feeding to be provided by the health care system. 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.

100. The activities described above were carried out not in isolation but as part of the larger programme of family health which focuses on maternal and child health and family planning, including improved infant and young child feeding, healthy child growth and development, and the betterment of the health and nutrition of the family as a whole. The overall programme constitutes an essential element of primary health care, and complements the WHO activities of technical cooperation carried out in collaboration with UNICEF, UNFPA, and other agencies within the United Nations system.

101. Special Programme of Research, Development and Research Training in Human Reproduction. This Programme has four main objectives: strengthening of research capabilities in developing countries; research on the safety of current methods of fertility regulation and development of new methods, on service and psychosocial aspects of family planning care, and on infertility; coordination of world efforts in this field; and dissemination of information to policy makers, service providers, scientists and the public.

102. In 1980 the Programme brought together in collaborative research and institution-strengthening the talents, skills and resources of scientists and administrators from 82 countries, 55 of them developing countries. During the year, in response to requests from Member States, there was a considerable increase in collaboration in strengthening national capabilities for research in family planning; this included major collaboration in institution-strengthening and research in China. Based on the results of studies completed in 1980 in the Special Programme's network of collaborating centres, guidance is now available to health authorities on the relative safety and efficacy of different oral contraceptives, intrauterine devices, procedures for sterilization, and national family planning methods.

103. Arrangements were made for the large-scale manufacture of the vaginal ring, a new contraceptive device developed by the Special Programme. Also in 1980, the chemical synthesis programme begun in 1976 continued, and by the end of the year a total of about 250 new compounds had been prepared in university and government laboratories in Australia, Brazil, Bulgaria, Iran, Israel, Mexico, Nigeria, Poland, Singapore, Spain and Sri Lanka. They were screened in small animals by the United States Center for Population Research. Compounds for testing in primates, for larger-scale synthesis and for preclinical toxicological studies were selected in November. The chemical synthesis programme is funded directly by WHO, indirectly by the United States National Institutes of Health through their support of the biological screening, and also indirectly by the participating laboratories, which cover most of the personnel costs. As yet, no new contraceptive agent has emerged from the chemical synthesis programme. Nevertheless, the programme shows promise and is noteworthy as being the first successful example of a multinational cooperative project in this field being established outside traditional pharmaceutical channels.

104. Health service research showed that nurse/midwives, when properly trained, can provide services concerned with intrauterine devices as well as, or better than, physicians. In March, a three-week training course was held in Geneva on health service research in family planning. The participants were senior administrators, public health physicians, epidemiologists, social scientists and statisticians from eight developing countries. Trainees developed protocols for studies to be implemented in their own countries, based on research issues identified by them with the national authorities prior to the course.

105. The Special Programme is the world's largest research training programme in family planning, with an expenditure of US$ 2 million in 1980, including doubling the number of research training grants awarded in 1979, and the holding of several research training courses. It is largely financed by voluntary contributions; in 1980 the donors included Australia, Cuba, Denmark, Finland, Federal Republic of Germany, India, Nigeria, Norway, Sweden, Thailand, United Kingdom, and UNFPA. To quote one regional example only, in the African Region the Special Programme received 61 contributions (30 for research, 28 for research training, and three for institution-strengthening); the total amounted to US$ 104 000.

106. Nutrition. In the South-East Asia Region, WHO supported the development of national food and nutrition policies, nutrition surveillance and training by means of short-term consultancies and seminars. A regional seminar and subsequent national seminars emphasized the importance of integrating nutrition activities within the context of primary health care.

The minimal nutrition component of primary health care was identified and guidelines were developed for training primary health care workers in nutrition. Work began on developing a regional strategy for setting up an action-oriented research, development and training programme in nutrition; the mechanisms used were a regional planning meeting followed by consultancy services and specific activities in countries.

107. Action-oriented nutrition research projects were initiated in almost all the countries of the Region, and detailed protocols were reviewed at a regional meeting of principal investigators in New Delhi in November, which undertook a situation analysis of the nutrition component of primary health care. A regional collaborating centre was developed in Bogor, Indonesia, for research and training in vitamin A and iron deficiency anaemia. A nutrition unit was established in Nepal. To train medical and paramedical personnel, national workshops and training courses on nutrition in primary health care were organized in Bangladesh, Mongolia, Nepal and Thailand. Several countries in the Region expressed interest in undertaking research projects on nutrition surveillance; contractual agreements were finalized and protocols developed.

108. At a WHO interregional workshop for trainers of community health workers in nutrition, held in Manila in February, it was stressed that nutrition was a most important aspect of primary health care. Emphasis was laid on the need for involvement and cooperation of the people, the only way by which primary health care could be carried out. Simple and realistic nutrition activities were recognized as constituting a cornerstone of primary health care, since malnutrition is probably the most glaring public health problem in the developing countries. The participants were reminded that WHO had developed simple, task-oriented training in nutrition for community health workers. The guidelines have been tested by a large number of trainers and the revised form is available for self-learning. The workshop elaborated methods through which such guidelines could be utilized in the light of national experiences. The participants in the workshop came from Bangladesh, Fiji, Greece, India, Maldives, Philippines, Republic of Korea, Sri Lanka, Thailand and Turkey.

109. Health education. In the African Region, the programme of health education continued to be directed towards training the trainers. Courses were given at the Regional Centre for Health Development, Cotonou; the African Regional Centre for Health Education, Ibadan, Nigeria; the WHO regional training centres at Lomé and Lagos; the Faculty of Medicine, Lusaka; and the Higher National Institute of Health Sciences, Brazzaville. With the support of UNFPA, ILO, FAO, UNESCO, WHO and the International Planned Parenthood Federation, four countries in the Region (Benin, Mali, Upper Volta and Zaire) organized national multidisciplinary workshops on subjects related to health education and information of the public. In July the recently created Association of Health Educators for Africa and Madagascar organized an inter-country seminar, attended by nationals from 14 French-speaking countries in the Region, on primary health care and health education and the role of health education in primary health care.

110. Most communities do not give high priority to health. Economic activities, building roads or school houses or producing food are usually considered more urgent. Health workers therefore may have to work in projects other than health in order to link up with or be considered part of community undertakings. It is important for the health services to initiate the move to establish the link with other development projects. However, it does not necessarily follow that the community will participate or get involved simply because of the first steps taken by the health workers. The community has to prepare itself for such involvement. These are among the issues discussed in the technical presentation made on the subject of "Community involvement in the development of health services" during the session of the Regional Committee for the Western Pacific in September. There was reference to case studies of experience in primary health care activities in four countries: China - the cooperative medical service; New Zealand - the Porirua community health project; the Philippines - the Carigara (Leyte) experiment; and Samoa - women's committees.

111. Health problems were stated to be formidable and complex; by focusing attention on the community and attempting to shift it from its passive role of compliance to one of active partnership, governments are following a logical approach. Only full partnership between the community and health professionals will give the necessary dynamism to health care systems. Ideally, community involvement starts with the individual who learns that he can exercise some

control over his own health. This leads to community awareness of health and diagnosis of health or health-related problems. At this stage technical and managerial support can come from outside the community to develop activities that will link up with government programmes. The key to the process is individual awareness and community action. Practical ways for developing community involvement were considered, but it was stressed that each community or society is unique and suitable approaches must be selected in each case in accordance with local conditions.

112. Mental health. The integration of mental health components into general health care is an essential part of the strategy of WHO's mental health programme. To achieve this integration and evaluate its effects, adequate assessment methods are needed. The Organization therefore initiated a project in which seven countries collaborated to develop new and adapt existing methods and techniques of monitoring the mental health needs and resources at community level; these were Bulgaria, Ghana, Kuwait, Panama, Papua New Guinea, Thailand and the United States of America. The objective was to identify all health, social and other services in well-defined communities with which mentally disturbed patients may have contact, to develop means for recognizing and recording characteristics of such patients that are relevant to the planning, monitoring and evaluation of mental health programmes, and to link this information with sociodemographic and socioeconomic data on the general population. The year saw the successful conclusion of the project; the collaborating investigators met to review achievements, exchange ideas on how to establish routine monitoring systems within their own countries, and agree on ways to disseminate information on the project's methodology and encourage other countries to undertake similar work. As a follow-up, a new project was initiated in 1980 to assess the usefulness of multiaxial recording and reporting of physical, psychological and social components of reasons for primary health care contacts. Centres in countries in all WHO regions agreed to participate in this project.

113. At the same time, another collaborative activity was under way, aiming to develop and test technology for the management of mental health problems at the primary care level.[1] The first phase of this study involved an epidemiological assessment of the study areas and the design of training courses for general health personnel. In 1980 the intervention phase took place, and investigators from seven countries (Brazil, Colombia, Egypt, India, Philippines, Senegal, Sudan) met early in the year to map out the final phase. The study is designed to investigate the extent of mental health problems in selected communities, the community reaction to mental disorders, and the possibility of providing basic mental health care for the millions of mentally ill people who today receive no effective treatment.

114. There is worldwide concern about the consequences of the increasing consumption of alcoholic beverages. WHO compiled an international review of the situation, based on a literature survey and contributions from more than 80 countries. The review was used as a background document for the meeting of a WHO Expert Committee[2] and also for a WHO project on community response to alcohol-related problems, which involves the collaboration of Mexico, Scotland and Zambia. Reports drafted on the experience in each country, as well as an international report, will be used for discussions of the implications with national authorities. Additional countries will be invited to embark on similar action-oriented projects.

115. In May the World Health Assembly discussed the abuse of narcotic and psychotropic substances and advocated that drug abuse control should be integrated in primary health care programmes. During the year WHO published the results of its study on drug programmes in the sociocultural context.[3] In collaboration with investigators from developing and developed countries, case studies were conducted at country level, followed by an analysis of common factors and differences among drug use patterns in the various countries; different approaches to the management of drug dependence were identified and sociocultural considerations were

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[1] WHO Chronicle, 34: 231-236 (1980).

[2] WHO Technical Report Series, No. 650, 1980 (Problems related to alcohol consumption: report of a WHO Expert Committee).

[3] Edwards, G. & Arif, A., eds. Drug problems in the sociocultural context: a basis for policies and programme planning. Geneva, World Health Organization, 1980 (Public Health Papers, No. 73).

found to be of central importance in selecting the health care approaches likely to achieve the desired results. Case studies were also selected as a method of work in a major study aiming to identify different country approaches to the prevention of drug dependence; here too, preliminary analyses demonstrated that sociocultural factors must play a determinant role in selecting action strategies. In 1980 WHO issued the following publications on research and reporting on the epidemiology of drug dependence, all in the WHO Offset Publication series:

No. 50. R. G. Smart et al. A methodology for student drug-use surveys.

No. 52. Lloyd D. Johnston. Review of general population surveys of drug abuse.

No. 55. I. Rootman & P. H. Hughes. Drug-abuse reporting systems.

No. 56. P. H. Hughes et al. Core data for epidemiological studies of nonmedical drug use.

116. Prophylactic, diagnostic and therapeutic substances. Within the framework of its action programme on essential drugs, WHO cooperates with Member States in formulating drug policies and management programmes that are relevant to the health needs of populations and aimed at ensuring permanent access of the whole population to essential drugs at a cost the country can afford. During 1980 the process begun in 1977 continued and the subject of essential drugs was discussed by regional committees and by working and study groups with the full participation of Member countries, emphasis being placed on national drug policies and technical cooperation, especially among developing countries.

117. A consultant visited several countries in the African Region and worked for six months on a programme of essential drugs, summarizing current views and concrete proposals on this subject. A national list of essential drugs was established in about 30 countries in the Region. On this basis, a provisional regional list was drawn up and circulated to Member States, of which 32 out of 43 approved it. In March the programme was discussed at subregional meetings. In June a delegation from ECA visited the Regional Office to define the spheres of technical cooperation between ECA and WHO. The following activities were identified for drug policy and management: feasibility study of materials available in the Region; feasibility study on various aspects of pharmacy, to facilitate the establishment of pharmaceutical industries; cooperation between ECA, UNIDO and WHO in establishing pharmaceutical factories and inspection laboratories; and cooperation with ECA in the programme of joint purchasing of drugs.

118. In the South-East Asia Region, WHO developed a programme on drug policies and management for cooperation with countries in strengthening their pharmaceutical supply systems for essential drugs. Indonesia and Thailand benefited from cooperation of this kind in regard to their primary health care programmes. In these two countries WHO was also active in the establishment, through the ASEAN mechanism, of a task force for TCDC in the field of drug legislation, evaluation and quality control. Related activities were undertaken in other countries of the Region: Bangladesh (as regards pharmaceutical technology in a recently established unit for the production of essential drugs), Burma (UNDP/FAO/WHO collaboration in strengthening the food and drug control administration and drafting the necessary rules and regulations), India (as regards establishing a national control laboratory in connexion with the testing of oral poliomyelitis vaccine, now prepared by the Haffkine Institute), Mongolia (in the planning of a production unit for biologicals), Nepal (in collaboration with UNDP and the Government of the Netherlands, a primary health care project with emphasis on the production, procurement, distribution and utilization of modern and ayurvedic drugs), and Sri Lanka (with regard to setting up a formulation unit for manufacturing essential drugs for primary health care, to strengthening national quality control, and to manpower development).

119. In October an intercountry meeting on drug policy and management, held at the Regional Office, identified problems, constraints and strategies in regard to pharmaceutical supply systems in the countries of the South-East Asia Region and defined WHO's role in promoting national self-sufficiency in this field.

120. In the Western Pacific Region, a revised draft memorandum of agreement for establishing the South Pacific Pharmaceutical Service was drawn up and sent to potential participating

countries for comments. A subregional workshop on drug quality control and management, held in Kuala Lumpur in February-March, was attended by participants from China, Malaysia, Philippines, Republic of Korea, Singapore and Viet Nam. In April a task force conducted a feasibility study on the implementation of seven identified areas for technical cooperation in pharmaceuticals among the ASEAN countries.

121. It is evident that conflicts can arise between the concepts of social justice and the public interest on the one hand, and the commercial interests of the pharmaceutical industry on the other. WHO continued its efforts to minimize these conflicts by meeting with 40 pharmaceutical companies to explore mutually acceptable avenues of cooperation. In addition, WHO participated with the pharmaceutical industry in joint fact-finding missions to assess country needs for essential drugs in support of national health services in Burundi, Rwanda, Somalia and Yemen.

122. During the year WHO participated in the activities of the United Nations interagency task force for the development of the pharmaceutical programme for the non-aligned and other developing countries. A further interagency activity in this field was the informal consultations held with UNICEF with a view to developing a joint UNICEF/WHO programme on the provision of essential drugs for primary health care to the less developed countries.

123. The revision of the International Pharmacopoeia continued, and during the year work was completed on the second volume of the third edition, containing monographs on 120 active substances selected from the list of the most widely used essential drugs, especially those important in primary health care.[1]

124. The Organization pursued its policy of transfer of technology by formulating international requirements for the production and control of vaccines such as those against rabies, hepatitis B and rubella, as well as updating the requirements for the vaccines against pertussis, diphtheria, tetanus and poliomyelitis.

125. WHO cooperated with Algeria, Burma, Nepal, Pakistan and Papua New Guinea in field operational studies on the establishment of peripheral laboratories. In this joint exercise, WHO and the government concerned study all the operational aspects of the establishment of peripheral laboratories, identifying problems and alternative solutions for them. Emphasis is placed not only on the establishment of small peripheral laboratory units to serve primary health care delivery and disease control, but also on the operational strengthening of intermediate and central laboratories essential for the functioning of peripheral units. In 1980 WHO also published a 487-page Manual of basic techniques for a health laboratory.

126. Traditional medicine. Three WHO collaborating centres for traditional medicine were designated in 1980, located in China, India and Mexico. Others were in the process of being established, in Ghana, Mali, Nigeria (2) and the United States of America (2).

127. WHO organized two training courses on acupuncture in China, in September-November, funded by UNDP. The first was a French-language course, held in Shanghai, and attended by 15 participants from the African Region. The second was an English-language course, held in Nanjing, and attended by 20 participants from the African, South-East Asia and Western Pacific Regions.

128. Literature on the administrative aspects of traditional medicine in relation to official health services is very scarce. To help bridge this gap, a handbook designed for use by health administrators and health workers was developed. The handbook, intended for issue in 1981, attempts to review the main concepts and systems of traditional medicine in selected countries, reviews current legislation on the subject around the world, and suggests procedures that might assist administrators wishing to extend their health services by making fuller use of traditional healers and indigenous health care systems.

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[1] World Health Organization. The International Pharmacopoeia, 3rd ed., Vol. 2 (Quality Specifications). Geneva, 1981.

Disease prevention and control

129. During the year WHO's activities in the field of disease prevention and control were reoriented in the context of primary health care. There is a shift away from the traditional containment campaigns directed against single disease entities, towards sharper epidemiological surveillance with problem-oriented approaches within the framework of technical cooperation. Interlinking with WHO's other major programmes is being improved. Also, the Organization is contributing to the planning, implementation and evaluation of communicable disease programmes as an integral part of national health services based on primary health care.

130. Epidemiological surveillance. In the Eastern Mediterranean Region, field work was started on the epidemiological surveillance of communicable disease in Somalia - in Merka, a regional capital, where the last case of smallpox in the world was registered, and cured, in October 1977. This activity will be extended to cover a representative sample from the population of all regions of Somalia. After implementation of the initial phase, in which WHO consultants will join, a Somali sanitarian will be assigned to each of the 16 regions of the country for follow-up after completion of the phase of operations. The project, financed by WHO and UNDP in the total amount of about US$ 824 000, aims at helping the Government in its efforts to control communicable diseases, one of the national goals of Somalia. This project, through the provision of data on the occurrence of these diseases in various parts of the country, can contribute largely to scientific planning for communicable disease control. Also, through the establishment of continuous surveillance activities, the project will help in the early identification of changes in disease occurrence and hence early intervention for implementation of control measures.

131. A regional workshop on the teaching of epidemiology was held in Manila in October-November. It was supported by the Special Programme for Research and Training in Tropical Diseases and included a promotional effort to integrate population-based studies into the curriculum of postgraduate medical students in particular. The workshop was attended by 22 participants, mainly from departments of epidemiology, community medicine or preventive medicine in the Western Pacific Region. Other topics discussed were the roles and functions of epidemiologists, manpower needs and the development of teaching material.

132. During the year WHO strengthened its epidemiological surveillance team in the South Pacific, stationed in Suva. There are now two epidemiologists, one entomologist and one microbiologist covering the needs of more than 10 countries or areas.

133. Malaria action programme. In the African Region, consultant teams from intercountry projects contributed to the development of antimalaria programmes in nine countries, analysing the general situation, and planning activities, the training and recycling of personnel, and the dispatch of supplies and drugs. Antimalaria training was given to 21 health workers at the training centre in Lagos and to 44 at the regional health development centre in Cotonou.

134. The Organization, in collaboration with the National University of Benin, Cotonou, organized a course for 11 nationals from French-speaking countries on the *in vitro* testing of *Plasmodium falciparum* sensitivity to 4-aminoquinolines. In collaboration with USAID, a support strategy was developed for antimalaria programmes in Africa (vector control, early treatment of disease, prevention in vulnerable groups). In this connexion two conference-workshops and an information tour were arranged in seven countries (Congo, Kenya, Senegal, Sierra Leone, Togo, United Republic of Tanzania and Zaire).

135. During its thirtieth session the Regional Committee for Africa studied the overall strategy for malaria control, recognized the need to reorient national and regional strategies, and invited Member States to formulate their national strategies accordingly.

136. The Regional Office for South-East Asia issued an up-to-date guide[1] to the diagnosis and management of acute malaria. This publication, which is particularly useful to staff of peripheral health institutions, has been in great demand.

[1] World Health Organization. *The clinical management of acute malaria*. New Delhi, 1980 (WHO Regional Publications, South-East Asia Series, No. 9).

137. In the European Region, the gravity of the malaria situation in Turkey continued to cause concern in 1980. UNDP and WHO set up a special intercountry project in 1978 to meet the challenge of resurgent malaria in south-east Europe, particularly in view of vulnerability and receptivity to the disease in several countries. To establish effective coordination of these antimalaria activities, WHO, in collaboration with UNDP and the Government of Bulgaria, held a meeting in Sofia in March. The participants included representatives from Bulgaria, Greece, Turkey and Yugoslavia (the countries in the project), as well as the Syrian Arab Republic.

138. In two of the countries (the Syrian Arab Republic and Turkey) malaria outbreaks have been occurring since 1976; while the epidemiological situation seems gradually to have improved, malaria transmission continues in several areas. Major efforts are directed to attack operations in order to reduce the endemicity level in active foci, whereas surveillance activities are performed in areas in the consolidation phase. Malaria eradication was certified in Bulgaria and Yugoslavia in 1965 and 1973 respectively. In Greece, the last indigenous cases occurred in 1975 (two cases) and 1976 (three cases) in villages on the west bank of the river Euros on the Greek-Turkish border. The existence of receptive areas and the increase of imported malaria cases in these three countries, and the persistence of transmission foci in the Turkish border areas close to two of them (Bulgaria and Greece) constitute a serious risk of reintroduction of the disease.

139. The meeting recognized the need for, and feasibility of, closer cooperation and exchange of expertise among the participating countries. It made a series of detailed recommendations concerning vigilance activities, a standard epidemiological information system, the use of immunological screening methods, cooperation with neighbouring Middle Eastern and European countries, training, and logistic matters.

140. WHO cooperated in the assessment of the antimalaria programmes of Democratic Kampuchea, Indonesia, Sri Lanka and the Syrian Arab Republic, and the Plasmodium falciparum containment programme in India. Preparations were made for the development of a malaria training programme in Asia as a cooperative effort of national training centres and WHO; the permanent secretariat established for this purpose will start functioning in Kuala Lumpur early in 1981. A seminar on field applied malaria research and a workshop on quantitative epidemiology held in China, a workshop on the continuous in vitro cultivation of P. falciparum held in the USSR, and courses on the assessment of drug sensitivity in P. falciparum, were among the major activies for the strengthening of epidemiological and research capacity. Research remained oriented towards the goal of improving malaria control and yielded significant methodological progress in the testing of drug sensitivity.

141. Information on national experiences in the area of primary health care and malaria control was gathered over 18 months by various means, including the holding of an informal meeting on this subject in the Regional Office for the Americas in July. A paper was prepared outlining the experiences of six countries (China, Costa Rica, Cuba, India, Thailand and Viet Nam). This paper was presented at the Seventh Asian Malaria Conference in Manila in November, and also at other meetings, including those convened for the joint mobilization of WHO and UNICEF staff (see also para. 25).

142. The Malaria Conference provided a forum for exchanging views on technical and other aspects of malaria control. Senior malaria and health workers from 27 countries in the South-East Asia, Eastern Mediterranean and Western Pacific Regions participated in the discussions. The Conference reviewed the current status of malaria in Asia, examined the role of malaria control within the strategy of health for all by the year 2000, considered immediate requirements for orientation and training in malaria control, reviewed recent advances in malaria research, and identified priority areas for research. The Conference recommended that malaria control should be maintained as a priority, in accordance with the strategy advocated by the World Health Assembly.

143. Parasitic diseases programme. Praziquantel is a newly developed antischistosomal compound that is not structurally related to previously used drugs active against human schistosomes. Following preclinical parasitological, pharmacological and toxicological studies and also double-blind studies of tolerance in healthy volunteers, the manufacturers suggested in 1975 that WHO might wish to cooperate in further research and development.

This cooperation led to the use of standard clinical trial designs and agreed technical protocols, the parasitological techniques of which varied with the species of infecting parasite. Coordinated by WHO and IARC, multicentre investigations of mutagenicity were carried out with respect to various biological systems. Next, double-blind assessments of tolerance and efficacy of three oral dose schedules against Schistosoma haematobium, S. mansoni and S. japonicum were conducted as a multicentre clinical trial in Brazil, Japan, the Philippines and Zambia, with extremely promising results. Many more clinical centres in Africa, South America and Asia then undertook trials of the efficacy of a wider dose range, using quantitative parasitological techniques. In 1980 field trials, also based on a common design, were nearing their final stages. This type of close professional cooperation with the pharmaceutical industry constitutes a useful model for initial clinicopharmacological studies and provides a new approach to research and development.

144. The Blue Nile health project in the Gezira-Managil and Rahad irrigation scheme, Sudan, initiated in July 1979, was further developed in 1980. It covers a population of two million and aims to prevent or control important water-associated diseases (malaria, schistosomiasis and diarrhoeal diseases) by means of a comprehensive multidisciplinary approach. As far as possible, national expertise is being used in the staffing of this project. Chief among the activities undertaken are environmental management, including improvement of the design of the irrigation and drainage system; assistance with operation and maintenance methods; and provision of water supply and latrine systems. The success of the programme will largely depend on the support of villagers - for instance, on their collaboration both in avoiding contact with polluted canal water, and in providing community labour for sanitation and drainage activities. Primary health care is receiving high priority, and the development of surveillance, diagnosis and treatment of water-associated diseases in conjunction with the project will play a key role. In research, the assessment of the impact of health on agricultural productivity is being emphasized. In 1980 both epidemiological investigations and methodologies for the diagnosis and chemotherapy of schistosomiasis were instituted in the project area. Particular attention was given to the irrigation scheme in Rahad, where no transmission of schistosomiasis has yet been found. Guidelines were provided for project staff, and field trials of specific drugs for the treatment of schistosomiasis (oxamniquine and praziquantel) were arranged.

145. For financing the project, a donors' meeting was held in February 1980 in Khartoum. A number of countries, as well as international and bilateral agencies, pledged their financial and technical support. The Blue Nile health project should significantly reduce the prevalence and incidence of schistosomiasis, malaria and diarrhoeal diseases, thus not only improving the health of the population in the areas of the irrigation schemes but also playing a positive role in the agricultural productivity of the area, which is of major economic importance to Sudan.

146. Following the end of the first year of the second phase of the Onchocerciasis Control Programme in the Volta River Basin Area, it was established that the extension of spraying in the Ivory Coast had limited reinvasion by the vector. In certain areas, where transmission had been completely interrupted, the infection rate in younger groups - which had ranged from 10% to more than 30% before the programme started in 1975 - came down to zero. These findings indicated that spraying should be further extended in Benin, Ghana, Togo, and to the Senegal River Basin. Epidemiological investigations confirmed that blockage of transmission had persisted. An economic planning course related to this activity was organized at the University of Clermont-Ferrand, France, in collaboration with the University of Michigan, United States of America, and was attended by nationals of Benin, Ghana, Ivory Coast, Mali, Niger, Togo and Upper Volta.

147. In recent years WHO, in cooperation with other organizations of the United Nations system (including UNDP, UNEP, FAO and UNESCO) and nongovernmental agencies, has developed a programme on water resources development and health. A major objective proposed at the inception of the programme was the elaboration of a set of guidelines, or a methodology, for the prevention and control of communicable diseases (especially those of a parasitic nature) liable to be introduced or increased in areas where water resources development was planned or was in progress. The original idea was to prepare such a methodology for the prevention and control of parasitic diseases on a global scale, covering situations which could be encountered in all parts of the world. It soon became apparent that this proposal was very ambitious and that a carefully planned regional approach would need to be undertaken,

the components of which could ultimately be integrated to provide for the varied situations encountered in different zoogeographical areas. The requirements of the wide range of users of such guidelines (governments, financing bodies, industry and engineering, public health workers and international organizations) also had to be kept in mind.

148. It was therefore decided to prepare a bibliography on the subject, and at the same time to carry out field surveys in selected areas representative of conditions prevailing in various parts of the world, special emphasis being placed on schistosomiasis, as this disease is typically associated with water projects in developing countries. Two editions of the bibliography have been issued, and at the end of 1980 a completely revised third edition listing 1250 references was nearing completion. Field surveys have been undertaken in Argentina, Brazil, Ghana, Ivory Coast, Paraguay and Venezuela, and in South-East Asia. Future plans include the preparation of guidelines on essential steps in the planning, construction and operation of water development schemes to avoid or minimize the introduction or spread of major communicable diseases, and investigation of the effects of small water impoundments on health, especially in Africa.

149. Leprosy. There are over five million cases of leprosy in the South-East Asia Region. In Bangladesh, WHO provided advisory services relating to training programmes and to evaluation of operational and epidemiological aspects of the control programme. In Burma, the rifampicin trial continued, including the treatment of open cases in the field; WHO cooperated in the BCG cohort study; and a field study was started to assess the prevalence and incidence of dapsone resistance. In India, WHO collaborated in exploring the possibility of opening reconstructive surgery units for treating deformities in leprosy patients, and also funded research and workshops; a SIDA-funded pilot project for multi-drug trials was begun; and the Damien Leprosy Foundation of Belgium supported epidemiological surveillance, the establishment of model leprosy control units, and the supply of drugs through WHO. In Indonesia, the Danish Save the Children Organization, through WHO, supported training projects. In the Maldives, a survey with 97% coverage showed that leprosy is endemic in 143 out of 202 inhabited islands. In Nepal, work on case detection, health education and the setting up of treatment clinics continued, with emphasis on the training of national auxiliary personnel in the basic health services, to ensure successful treatment and case-holding; community participation and the introduction of multi-drug regimens were begun in two districts with support from WHO and the Japan Shipbuilding Industry Foundation. In Thailand, emphasis was given to the training of basic health workers at the peripheral level; and surveys on dapsone resistance and the use of multi-drug regimens were begun with support from the Japan Shipbuilding Industry Foundation, which also funded various other leprosy control activities in the Region.

150. An intercountry consultative meeting held in New Delhi in June reviewed the current status of leprosy control and research in the South-East Asia Region in the light of problems such as dapsone resistance. The meeting formulated criteria for the provision of multi-drug regimens, suggested specific regimens for field use, and identified and developed protocols for specific areas of research (chemotherapy, epidemiology, immunology, and operational problems).

151. A WHO meeting in Mogadishu in February reviewed guidelines for leprosy control, training and research activities and identified special problems in the Eastern Mediterranean Region with regard to leprosy control as part of primary health care.

152. Courses in leprosy were held at the Leprosy Training Centre in Suva in February (11 participants from six countries) and September (12 participants from eight countries). Leprosy is an important problem in several countries in the Western Pacific Region, and training is emphasized in their leprosy control programmes.

153. In view of the high priority assigned to leprosy control within the concept of primary health care in a number of countries, and also in view of recent changes in leprosy control procedures, it was agreed at a UNICEF/WHO meeting in June that UNICEF would provide support not only in the form of drug supplies and equipment but also in the wider context of joint formulation of plans of action, with emphasis on the formulation of programmes including the training of multidisciplinary health care staff.

154. In 1980 WHO published A guide to leprosy control, which incorporates as far as possible the latest advances in knowledge of the disease, and also guidelines recommended by recent international conferences on leprosy, the WHO Expert Committee, and other groups. The guide is addressed in particular to health programme managers and pays special attention to the process of project formulation.

155. Tuberculosis control. The World Health Assembly in May expressed concern about the inadequacy of efforts in tuberculosis control programmes, urged Member States to give earliest attention to the application of tuberculosis control as an integral component of primary health care, and stressed the need to promote programme evaluation, epidemiological surveillance and health services research in this field.

156. The results of a large-scale controlled field trial on the effectiveness of BCG vaccination, carried out in southern India with support from WHO, showed no evidence of a protective effect against bacillary pulmonary tuberculosis after 7-1/2 years of follow-up.[1] An Indian Council of Medical Research/WHO Scientific Group, convened to examine the findings, confirmed the high standard of the scientific investigations carried out, but considered that, in view of several epidemiological and immunological peculiarities in the study area, the results could not necessarily be extrapolated to other areas.[2]

157. A WHO Study Group examined the current BCG vaccination policies in the light of all the available information.[3] The Group found itself in substantial agreement with current BCG vaccination policies, and recommended the continued use of BCG as an antituberculosis measure. In the view of the Group, the results of the Indian trial serve to highlight the fact that there are situations in which the effectiveness of BCG cannot be predicted with certainty. Every effort should be made to identify the local factors that apparently may modify the outcome of BCG vaccination, but in the meantime it would be wise to go on using BCG, particularly in infants and children. Since the tuberculosis problem differs from country to country, the kind of BCG programme chosen must be based on the local epidemiological situation; in countries with a high prevalence of tuberculosis, for instance, BCG vaccination should be administered as early in life as possible. The Group stressed that BCG vaccination should not be considered in isolation as a means of tuberculosis control, but should form part of a comprehensive control programme that includes case-detection and treatment.

158. Virus diseases. In support of its major programmes in acute respiratory infections, diarrhoeal diseases and immunization, the Organization continued to encourage the development of simplified and rapid techniques for the diagnosis of viral infections. Hitherto, most virological techniques have been cumbersome and inapplicable in many countries. Newer techniques which simplify specimen collection and the necessary laboratory structures and equipment are being developed in a WHO collaborative programme with countries. This programme involves the evaluation of new methods, the preparation of guides, the production and distribution of reagents and the organization of training workshops.

159. A Scientific Group was convened in Geneva in September-October to examine the progress made recently in this area and advise on the further research necessary to make these methods of value in the context of primary health care.[4] The Scientific Group reviewed the technical characteristics - advantages and disadvantages - of several rapid techniques recently developed or adapted for the rapid viral diagnosis through the detection of antigen and early antibody, as applied to various types of disease. In addition, the Scientific Group examined the problems of standards and quality control relating to the reagents used in the techniques. It also advised on how WHO might expand its efforts in this field.

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[1] Bulletin of the World Health Organization, 57(5): 819-827 (1979).

[2] WHO Technical Report Series, No. 651, 1980 (Vaccination against tuberculosis: report of an ICMR/WHO Scientific Group).

[3] WHO Technical Report Series, No. 652, 1980 (BCG vaccination policies: report of a WHO Study Group).

[4] WHO Technical Report Series, No. 661, 1981 (Rapid laboratory techniques for the diagnosis of viral infections: report of a WHO Scientific Group).

160. Diarrhoeal diseases control. In the African Region 21 countries requested WHO collaboration in the control of diarrhoeal diseases. Burundi, Ethiopia, Gambia, Ghana, Kenya and Rwanda formulated plans of action in this field. Feasibility studies on the manufacture of oral rehydration salts were carried out in Ethiopia, Kenya and Zambia. An advisory group met in Brazzaville in July and recommended the primary health care approach, and especially community participation, for this purpose. Cholera epidemics occurred in Congo, Kenya, Mozambique, Rwanda, Uganda, and the United Republic of Tanzania.

161. Two WHO collaborating centres for research and training in the control of diarrhoeal diseases were designated in the South-East Asia Region, in Bangladesh and India: the International Centre for Diarrhoeal Diseases Research, Dacca, and the National Institute of Cholera and Enteric Diseases, Calcutta. A training course for country programme managers in the control of diarrhoeal diseases was organized in Bangkok in October-November. Technical support for the development of diarrhoeal disease research protocols was provided to Member countries in the Region. A working group on diarrhoeal diseases was established to advise on the development and implementation of a services and research programme in this field. An intercountry meeting on this programme was organized in New Delhi in November to review the current national control programmes and develop an outline of major activities for the next three years. During the year services and research in the Region greatly benefited from the availability of extrabudgetary resources.

162. Diarrhoeal diseases are the most common cause of admissions and outpatient attendance in paediatric hospitals in Egypt. They kill 50 000 infants and over 100 000 children under the age of five annually and also retard physical and mental growth and impair the quality of life of those who survive. To help in combating this problem, WHO collaborated with the University of Alexandria in establishing an oral rehydration training and demonstration centre at El Shatby Hospital. The centre is planned to serve the national diarrhoeal disease control programme. A WHO consultant provided practical demonstrations of the effectiveness of oral rehydration in the treatment of diarrhoea. Three members of the staff visited the WHO collaborating centre in Dacca, mentioned above, on WHO fellowships.

163. The Western Pacific Regional ACMR meeting in April established a subcommittee on diarrhoeal diseases to promote and develop research on this subject in the Region. The subcommittee met in April and reviewed current research in the Region, identified priorities for research and suggested mechanisms for the establishment and funding of research. During the year the Region's diarrhoeal diseases research programme was elaborated, consisting of two main elements: cooperation with Member countries in planning their national programmes, and the promotion and implementation of oral rehydration therapy. A training module on the management and prevention of diarrhoea, intended for training middle-level health personnel (public health nurses and midwives) was developed and field-tested in the Philippines. A seminar-workshop on clinical management of diarrhoeal diseases was held in Manila in October. An inventory was drawn up of national health officials and institutions involved in the control of diarrhoeal diseases and with a potential for conducting operational research.

164. In fact, in all six WHO regions there have been meetings of senior national public health administrators and scientists to discuss how national plans for diarrhoeal disease control might be developed, and to determine how WHO could best cooperate in these programmes. By the end of 1980, these meetings had helped to stimulate the development of plans of operation in over 70 countries for national programmes as an integral part of primary health care. The emphasis was on reducing mortality from diarrhoea - by the early treatment of acute diarrhoea with an oral rehydration solution recommended by WHO and UNICEF - and on reducing morbidity from diarrhoea, by improving relevant maternal and child care practices, by improving environmental health, and through the detection and control of epidemics. Globally, the target is to provide, by the end of 1983, access to treatment by oral rehydration therapy to 25% of cases of diarrhoea occurring in children in developing countries under the age of five.

165. One of the major constraints to the setting up of national programmes was obtaining an adequate supply of prepackaged oral rehydration salts. With the support of UNICEF, WHO cooperated with countries in overcoming this difficulty and in meeting national needs. Guidelines for local production were made available, and 13 large-scale production centres were in operation.

166. The training aspects of the programme focused on national staff with managerial, supervisory and training responsibilities. Courses, which were modified at regional and national level to meet local needs, provided instruction on the best means of implementing diarrhoeal control activities within primary health care services and on building an evaluation scheme for assessing the impact of the programme. A project was under way with UNDP to establish regional technical training centres in the South-East Asia and Western Pacific Regions. A manual of operations and four technical training manuals were completed.

167. The programme had the support of the United Kingdom, the World Bank, UNDP, UNICEF, SIDA, and other international organizations and bilateral and multilateral agencies. A total of 180 letters of intent (more than 40% from developing countries) were received from scientists desirous of receiving support, and initial steps were taken towards funding research projects.

168. Expanded Programme on Immunization. By the end of 1980, the impetus of the global Expanded Programme on Immunization had stimulated planned activities in more than 100 developing countries to increase protection of their infant populations against diphtheria, whooping-cough, tetanus, measles, poliomyelitis and tuberculosis. The goal of the Programme is to provide immunization protection to all of the world's children by 1990, and the more immediate target is to increase the present estimated coverage of 20% to 50% by 1983.

169. By the end of September, 28 countries in the African Region were operating an expanded programme on immunization and others were about to do so. Training activities continued. An interregional high-level management course was held in Brazzaville, attended by 24 nationals from the 16 French-speaking countries in the Region, and five from other regions. National courses, organized whenever possible in collaboration with neighbouring countries, were held in eight countries and being prepared in eight others. Nationals were used more and more as course promoters. The courses on immunization were adapted to teaching by training centres in the Region, as a module of primary health care.

170. In the Region of the Americas, the revolving fund for the purchase of vaccines and related equipment was consolidated, with the participation of 22 countries and eight territories. A regional centre was established at Cali, Colombia, for developing and manufacturing cold boxes and carriers for the programme in Latin America. It forms part of a project with the long-term goal of strengthening cold chain systems (i.e., systems of methods and materials for the distribution and storage of vaccines in developing countries) in the Region.

171. The Global Advisory Group of the Expanded Programme on Immunization held its annual meeting in Geneva in October. The Advisory Group consists of 12 members nominated so as to provide geographical and technical balance. It discussed global strategies, programme implementation and research and development. It reviewed global and regional activities and endorsed an outline for WHO's research on poliomyelitis, polioviruses and poliomyelitis vaccines, prepared by a WHO working group, also in October. Examples of evaluation activities that had been carried out were national programme evaluations in seven countries, cost analyses in three countries, the development of an information system to assess the quality of the vaccines being used, and 25 immunization coverage surveys (during 1979-1980).

172. The year saw considerable evolution in the type and extent of training for the programme. Priority for interregional training of senior-level staff in planning and management shifted to emphasis on national training in three areas: management for middle-level supervisory personnel, logistics and the cold chain, and maintenance and repair of cold chain equipment. Moreover, the training materials were integrated into national health training and broadened to cover other primary health care interventions. An example of the training courses mentioned above was the interregional senior-level planning and management training course held in Manila in August.

173. Systems of vaccine distribution were improved in eight developing countries. Vaccine packaging and shipping procedures were also improved following an analysis of current methods and the preparation of draft guidelines. Equipment for the storage and transport of vaccines was identified in two ways: independent testing of existing equipment by laboratories in

developed countries, to establish whether it is suitable for use in tropical countries, and the development of new equipment and the adaptation of existing equipment to meet the requirements of developing countries. The product information system already in operation was expanded. Considerable support was provided by UNICEF and the Consumers' Association (United Kingdom). Activities in the field of the cold chain provide an excellent example both of the development of appropriate technology and of TCDC.

174. Special Programme for Research and Training in Tropical Diseases. In 1980 this global programme of international technical cooperation, initiated by WHO and co-sponsored by UNDP and the World Bank, made significant progress towards its two objectives: (1) research and development towards new and improved tools to control six tropical diseases (malaria, schistosomiasis, filariasis, trypanosomiasis - both African sleeping sickness and Chagas' disease, leishmaniasis and leprosy); and (2) the strengthening of national institutions, including training, to increase the research capabilities of the tropical countries affected by the diseases. Up to 30 December 1980, the Programme had supported 1088 projects; and over 2000 scientists from 109 Member States participate in the planning, implementation, operation and evaluation of the Programme. More than US$ 52 million has been obligated for direct support to national scientists and institutions. The percentage of the project operations budget going to developing endemic countries has risen from 29% in 1977 to 56% in 1980.

175. Early scientific results include progress in chemotherapy for malaria, schistosomiasis and filariasis; in biological control of vectors; and in simple and accurate diagnostic field tests for malaria, leprosy and African trypanosomiasis. At the same time institution-strengthening and training support, awarded exclusively to institutions and scientists of developing countries where the diseases are endemic, has increased rapidly. Over 210 individual training grants have been awarded and 22 institutions are receiving long-term support. Twenty-three governments (including those of six developing countries where the diseases are endemic), and six other organizations, together with UNDP and WHO, have contributed over US$ 70 million to the Programme. The Joint Coordinating Board approved maximum budgets of US$ 26.51 million for 1980 and US$ 30.09 million for 1981.

176. The fifth meeting of the Research Strengthening Group of the Special Programme was held in Geneva in September, to discuss policy and priorities and to consider requests for funding. It was stressed that initial reports from Group-supported institutions showed that their relationships with the Group were at a very early stage, and that the Group should not allow individual problems to create doubts about the overall plans and policies. The creation of a viable research capability in developing countries was an important long-term aim and could not be expected to produce immediate results.

177. In view of the large number of requests received for funding for various activities, the Group felt that it should review its policies and, in some cases, establish stricter guidelines for the granting of awards. It decided to focus all grants for research training fellowships on the objective of institution-strengthening, irrespective of whether the request came from an institute, an individual, or a scientific working group. Courses, workshops, and seminars would be supported only if they were relevant to the Special Programme, and if they were likely to advance research or make an identifiable contribution to institution-strengthening.

178. The Group reiterated that internal evaluation is a required component of long-term support grants, intended mainly to improve the management of the supported institutions and thus the use and effectiveness of the grants. The Group examined 20 proposals for renewal of long-term funding and approved 18 of them. Of 13 new proposals, funding was recommended for four capital grants, two long-term support grants, and three courses. Three proposals were deferred and three were not accepted.

179. Vector biology and control. Taking into account the recommendations of the WHO Expert Committee on Vector Biology and Control,[1] UNEP, FAO and WHO in 1980 strengthened coordination

[1] WHO Technical Report Series, No. 649, 1980 (Environmental management for vector control: fourth report of the WHO Expert Committee on Vector Biology and Control). Also published during the year was WHO Technical Report Series, No. 655 (Resistance of vectors of disease to pesticides: fifth report of the WHO Expert Committee on Vector Biology and Control).

of their activities for better prevention of the waterborne and vectorborne diseases associated with the development of water resources. Interagency cooperation was agreed upon for the closer monitoring of water development schemes so that the necessary prevention measures can be considered at the time of planning such schemes. A memorandum of understanding concerning specifically that cooperative effort was signed. Efforts are being made to broaden its scope to involve other organizations and institutions (see also para. 147). Special emphasis was given in 1980 to WHO-sponsored research on the biological control of vectors as part of the Organization's efforts for developing integrated vector control strategies that could be used at the community level.

180. A biological larvicide, extremely safe for man and the environment, derived from Bacillus thuringiensis (serotype H-14), which gave very promising results when evaluated against blackflies and mosquitos, reached the stage of industrial production for large-scale operational use. In 1980, in one part of the zone covered by the Onchocerciasis Control Programme in the Volta River Basin Area, the larvae of one of the local vectors of onchocerciasis developed resistance to temephos, the larvicide used for controlling onchocerciasis vectors in that area for the last six years. It was possible to control temephos-resistant vectors by using chlorphoxim, an alternative larvicide screened earlier for that purpose in anticipation of such an eventuality. Action was also immediately taken to speed up the operational evaluation of other environmentally safe larvicides to minimize problems associated with cross-resistance. A large-scale field trial of the experimental larvicide derived from Bacillus thuringiensis was made within that context with promising results. This trial indicated that a wide-scale use of this biological larvicide may be possible after further research on industrial production and formulation.

181. One of the serious constraints in the prevention of vectorborne diseases is the shortage of adequately trained national personnel able to develop vector control tools, methods and strategies more appropriate to the socioeconomic and cultural conditions of the countries where these diseases are endemic. A network of institutions which will train specialists in vector biology and control to the Master of Science level was being strengthened under the aegis of the Special Programme for Research and Training in Tropical Diseases. Medical entomology and vector control courses were sponsored in Bogor (Indonesia), Abidjan, Nairobi, Jos (Nigeria), and Valencia (Venezuela). They will serve a number of countries in the spirit of TCDC. Efforts are being made to develop this network further and expand it to cover additional epidemiological zones.

182. Noncommunicable disease prevention and control. A WHO consultation held in Geneva in June advocated an integrated programme in this field, with WHO collaborating in the setting up of integrated programmes in both developed and developing countries. Where such programmes already exist, for instance in the field of cancer and cardiovascular diseases, further development should be encouraged. Use should be made of experience already gained in such centres as Gabrovo (Bulgaria) and North Karelia (Finland). Methods of influencing populations to change to more healthy lifestyles should be further explored.

183. One example is the prevention and control of cardiovascular diseases at the community level, the basis of one WHO programme that embraces the concept of primordial prevention, stressing the need to take appropriate action at an early stage to prevent the development or entrenchment of those social, economic and cultural patterns of life that have been shown to contribute to the incidence of cardiovascular diseases in populations. Plans were prepared in 1980 to launch an approach to primordial prevention in developing countries, to see whether, if the occurrence of risk factors is prevented, cardiovascular disease can be prevented from reaching the epidemic proportions experienced in industrialized countries. Initially, community smoking control activities will provide the main thrust to primordial prevention; WHO will collaborate with a limited number of Member States to develop, implement and evaluate methodologies of field surveys of the smoking situation and of community smoking control programmes adapted to local conditions and needs. Attention will also be paid to other cardiovascular disease "risk factors" such as unhealthy dietary habits, hypertension, obesity and lack of exercise.

184. The results of the first five years of the North Karelia project on the comprehensive control of cardiovascular disease in the community became available and are now being published by the Regional Office for Europe. Also in the European Region, the coordination of hyperten-

sion research related to health care was welcomed by 25 countries, of which 16 contributed with projects at the national level. A 10-year study on the community control of hypertension was concluded; the results were discussed at a final meeting of the investigators in December in Geneva and the report will be published in 1981.

185. The year saw the widespread acceptance of 3 DMF (an average of three decayed, missing or filled) teeth at the age of 12 years as an indicator of oral health by the year 2000. The International Dental Federation collaborated in developing interrelated indicators for other ages or age-groups and pertaining to other oral diseases and conditions. Emphasis was placed on developing a standard method for situation analysis and coordinated planning in the oral health sector,[1] and a demand for this approach was common to highly industrialized and developing countries. The year marked the beginning of a long-term programme to achieve oral health, an indication of the extent of achievement being the 3 DMF teeth "barrier"; evaluation of progress will have as a base global data bank information for 1980. The trend towards decreased oral disease in highly industrialized countries, associated with a continuing high level of manpower production, has reached a stage at which dental manpower excesses of considerable proportions are likely in a number of these countries. Consideration was therefore given to WHO's role in devising a process for balancing such excesses, when they occur, with worsening manpower deficiencies in developing countries.

186. During 1980 field trials of the basic radiological service project were started in Yemen and were at an advanced preparatory stage in Colombia and Egypt. The basic radiological system is a solution for improving the coverage of the population with diagnostic radiology and includes appropriately designed X-ray machines and training packages for operators and general practitioners. It is aimed at providing technical support for primary health care activities. The development of this system was treated as a priority area since it offers a realistic solution to the problem of adequate radiological coverage of populations in developing countries and rural areas of some developed countries. Technical specifications for the machines involved were finalized and circulated to manufacturers. A manual for machine operators was drawn up and work begun on another for general practitioners involved in interpreting films produced by the equipment. Two consultations of the WHO advisory group on this system took place in June (Amsterdam, Netherlands) and December (Copenhagen) to discuss results and plan the development of the project.

187. In 1980, in the Region of the Americas, a model of technical cooperation was successfully implemented in cancer research among oncology institutions in Latin America and the United States of America entitled "Latin America Cancer Research Information Project" (LACRIP). The project was made possible through technical assistance and contracts of US$ 2 900 000 from the United States National Cancer Institute and the United States Environmental Protection Agency. It includes specific activities reflecting the transfer and adaptation of appropriate technology, the training of junior personnel focusing on local needs, the strengthening of institutions through direct support, and the promotion of formal cooperation among centres within a given country. It also provides for a dynamic information system for dissemination and collection of cancer research information and an annual meeting of participants to review progress and design future plans of action. By the end of the year, LACRIP included the formal participation of 53 institutions and 95 investigators from seven Latin American countries and the United States of America in clinical trials and epidemiological research, and 3500 scientists throughout the Region were participating in the information exchange activities.

Promotion of environmental health

188. In May the World Health Assembly endorsed the basic policy for WHO's participation in the International Drinking Water Supply and Sanitation Decade, 1981-1990 (see para. 50), with a view to implementing this most essential element of primary health care. WHO provided information on water supply and sanitation in more than 100 countries and disseminated it widely as a means to promote the Decade and attract more resources for it. In 33 countries programmes of technical cooperation were undertaken for the development of national plans. At the regional level, WHO used political and technical avenues to increase awareness and stimulate commitment for the Decade and to provide guidance for planning and implementing national

[1] World Health Organization. Planning oral health services. Geneva, 1980 (WHO Offset Publication No. 53).

programmes and for supporting them. At the global level, the flow of information between Member States and the donor community was accelerated with a view to increasing external participation in the Decade. WHO continued its close relationship with other agencies, particularly UNDP, UNICEF and the World Bank, but also others, and provided secretariat services for the Decade Steering Committee.

189. Under an agreement between the Federal Polytechnic School, Lausanne, Switzerland, and the Inter-State School for Rural Public Works Engineers, Ouagadougou, October saw the opening of a year of specialization in health engineering. The agreement provides for enhanced cooperation with WHO. In collaboration with DANIDA and the World Bank, workshops for training high-level staff in planning and management techniques relating to the Water Decade were organized in Algeria, Congo, France, Ethiopia, Gabon and Kenya.

190. In March the Agency for Technical Cooperation of the Federal Republic of Germany (GTZ) concluded an agreement with WHO on the subject of planning in Niger, Rwanda and Upper Volta for the Decade. Also in March SIDA signed an agreement with WHO covering similar activities in Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Swaziland, Uganda and Zambia. The GTZ/WHO activities began in July with a mission to Niger; later there was a mission to Rwanda and a workshop in Upper Volta. By the end of the year, the permanent staff for the project were being placed. Also by the end of the year, most of the countries of the African Region had prepared their situation reports as required by resolution 1979/31 of the United Nations Economic and Social Council. The countries responded to an invitation by ECA to a conference organized at Addis Ababa in August on the subject of the Water Decade, at which the situation reports proved to be most useful, and for which WHO prepared all the technical documentation. Ten countries received loans from the World Bank for water supply and sanitation projects, and three other countries were under consideration for the same purpose.

191. In the Region of the Americas, three aspects of human resources development were stressed: planning, training and education, and utilization. A symposium on environmental manpower development was held in Rio de Janeiro in collaboration with the Brazilian National Housing Bank and the Brazilian Association of Sanitary Engineers, with the participation of 40 professionals from 18 countries of the Region, and representatives of funding agencies. The Caribbean Water Basin Management Project, supported by CIDA and the International Reference Centre, aims to upgrade the quality of local water systems, chiefly through the development of a self-sustaining training delivery system for water and sanitation utility personnel. A complementary project at the Pan American Center for Sanitary Engineering and Environmental Sciences, supported by the Inter-American Development Bank and the Government of Peru, is also directed towards improving the operation and maintenance of water and sanitation systems; the emphasis is on the training of trainers, the development of information exchange activities, and the investigation of problems associated with water distribution and disinfection. Another approach to manpower development in Central America was the formation of an association of managers of water supply and basic sanitation agencies; this collaborative network facilitates the exchange of experiences, personnel and equipment, as well as the development of materials and programmes to train trainers - an excellent example of TCDC.

192. The support of lending institutions and bilateral agencies proved invaluable in the Region of the Americas. Activities included strenthening of national capacities for identifying and developing projects, among them projects relating to pollution control. For the first time, the World Bank proposed to make funds available to a governmental agency, which could in turn reimburse industry for control devices to solve specific pollution problems. GTZ cooperated with WHO by funding projects in Bolivia, Haiti and Paraguay for infrastructure development prior to implementing water and sanitation improvement projects.

193. The following are some examples of international cooperation in the development of national plans for the Water Decade in the South-East Asia Region during 1980. There was a UNDP interregional project, with WHO as executing agency, involving Bangladesh (with inputs from the WHO/World Bank cooperative programme under consideration), India (whose plan is expected to be ready early in 1981) and Nepal (whose plan was completed in 1980). The Government of the Federal Republic of Germany cooperated with Burma, Indonesia and Thailand, using WHO as the executing agency. With the active participation of WHO, USAID provided technical and financial resources for Sri Lanka. Donor agencies supported many other high-priority projects for the Water Decade in the countries of the Region.

194. In the Eastern Mediterranean Region, pre-investment studies were begun for a national waste management plan for Lebanon. In January, a regional seminar on the design and operation of waste stabilization ponds was held in Lahore, Pakistan, to develop technology appropriate to the conditions in Member States. WHO collaborated with the Institute of Public Health Engineering and Research, Lahore, in establishing postgraduate training facilities.

195. The Eastern Mediterranean Region's largest UNDP-funded rural water supply project was initiated in Sudan. A first batch of hand-pumps was ordered in 1980, for installation in the south of the country before the next rainy season, as part of the project, executed by WHO, to provide one million people with a safe supply of drinking-water. The project is expected to last for about eight-and-a-half years, carries a budget of US$ 6 million in addition to 1.5 million Sudanese pounds, and is concerned mainly with the provision of hardware: supplying drilling rigs, pipes and pumps, and boring a large number of wells. Institution-strengthening and manpower production have not been forgotten, however: by the end of the project, the local government will be able to take over all functions of the development programme, including water resources control. Similar programmes are going on in other parts of the Region, some of them supported by UNICEF and nongovernmental organizations. WHO has the task of coordinating all these programmes.

196. WHO's second major priority in the field of the environment is the recognition, evaluation and prevention of adverse effects on health resulting from chemicals and other environmental hazards in air, water and food. During 1980 an international programme on chemical safety was launched jointly with UNEP and ILO. The World Health Assembly had decided that such a programme would be implemented through the delegation of specific tasks to national institutions. The programme's initial priorities include the evaluation of the health effects of priority chemicals, the dissemination of information (to be implemented through UNEP's International Register of Potentially Toxic Chemicals), the development of methodology for risk evaluation and hazard assessment, and the training of manpower. Nine Member States actively joined the programme in 1980 and agreed to assume specific tasks through their scientific institutions.

Health manpower development

197. It has truly been said that, while people can make buildings, buildings cannot make people. Constructing health centres is useless if there are no personnel to staff them. Equally, teaching institutions serve no useful purpose unless they are producing staff with the motivation and training to deal with local conditions. The main problems are the shortage of health workers, their maldistribution (both nationally and internationally), and the fact that their training is related neither to existing services nor to needs. In 1980 the basic principle of WHO's health manpower development programme was collaboration with Member States to satisfy the health needs of their populations through health services made up of teams of health workers functioning at the most peripheral level of the health service as is practicable. The main aim of the programme is to help bring about a change in the health manpower development process so that it will be relevant to the present and foreseeable future health needs of the communities in Member States.

198. The health manpower development programme in the African Region laid particular stress on the training of health personnel in the management process for health development. To this end, the regional health development centre established in Cotonou provided common training for 40 health workers of various kinds from 13 countries. The course consisted of modules dealing with health and development, management, primary health care, and research and development. The training was given in the form of workshops and made use mainly of teaching material produced by WHO.

199. The first regional meeting of education and health administrators, organized in collaboration with UNICEF and the World Federation for Medical Education, took place in Brazzaville in December. Deans of faculties and institutes of health sciences participated. The aim of the meeting was to promote mechanisms for integrated health manpower development at all levels. The meeting approved broad outlines for training in basic medical sciences and stressed the need to introduce clinical disciplines as from the first year of these studies. Curricula should be reinforced, taking into account the objectives of primary health care. In order to improve the quality of teaching, the participants approved in

principle the establishment of an African regional network for the production and distribution of textbooks and teaching materials.

200. An interregional project on the training of teachers of community health workers with particular emphasis on family health, already initiated in Sudan and Papua New Guinea, was extended to the United Republic of Cameroon during the year, with the full support of the Ministry of Health. A building for a proposed health centre, located in a village 70 km from the capital, was improved and enlarged with the voluntary assistance of the community. The health centre/training school will develop the training of teachers and supervisors of community health workers in conjunction with a community health care programme. A training workshop for resource staff took place in June, and the first regular course for teachers and supervisors of one province of the United Republic of Cameroon began in October. In relation to the project, a study of job specifications of all workers was being planned as a starting-point for the reformulation of training programmes and for the effective management of health personnel and health services.

201. In the Region of the Americas, the Latin American Center of Educational Technology for Health, Rio de Janeiro, developed in 1980 the first course of specialization in educational technology for health. The objective of the 11-week course is to give professions an opportunity to participate in learning experiences from the fundamental courses, with the topics being developed to a greater depth. It is intermediate between the short courses and the Masters' degree courses also offered by the Center. Fifteen participants attended the course in 1980.

202. In the Eastern Mediterranean Region, WHO provided technical advice and support for the planning of new medical schools in Bahrain, Egypt and Yemen, and to the newly established school in Sudan. Those responsible for the new schools are applying modern approaches in educational planning, taking into account the needs of the health services and the resources available, and defining the tasks to be performed by their future graduates in close collaboration with those who will employ them. WHO collaborated in organizing the first workshop on curriculum planning for the new medical school in Yemen mentioned above. In an effort to promote approaches in training that will prepare physicians capable of playing a socially constructive and relevant role, WHO sponsored a workshop on problem-based learning, alternative instructional approaches, and the role of the medical school in providing area health services; the workshop took place at the University of Maastricht, Netherlands, with 10 participants from education centres in Bahrain, Iraq, Jordan and Sudan.

203. The Health Manpower Institute, Sana'a, which trains many health personnel other than physicians, ran a workshop on task analysis and curriculum design in the training of auxiliaries; the workshop undertook a complete review of the extent to which the present curricula for the several categories of health worker meet the defined needs of the country. A working group on teaching/learning materials for medical assistants prepared a set of books for this category of staff and the same approach will be used in preparing suitable materials for other categories of middle-level health personnel.

204. In cooperation with three nongovernmental organizations (the International College of Surgeons, the International Federation for Hygiene, Preventive Medicine and Social Medicine, and the World Medical Association), WHO developed studies on the role and tasks of team leaders in primary health care. Each of the three organizations selected a few countries in which to conduct the study. There will be an analysis of the existing literature in the country on the role and tasks of leaders of primary health care teams in the prevention of disease, health promotion and the management of primary health care services and personnel. The role and tasks of the leaders of primary health care teams in each country will then be identified, taking into account the composition of the different teams and the role and tasks of their members. The final task, to be completed in 1981, will be the preparation of a report covering these issues and recommending possible modifications of the present role and tasks of team leaders.

205. With a view to promoting the training and utilization of community health workers and the mobilization of traditional practitioners, such as traditional birth attendants, WHO pursued the development of a learning system and strategies for teachers of traditional

practitioners. Included are training in maternal and child health care and family planning, as well as teaching techniques used in adult education and in literacy programmes. WHO also carried out research and study directed towards a better definition of how traditional birth attendants can contribute to primary health care, for instance, in the screening of high-risk mothers and children, and how they can work alongside the formal health system.

206. The following are some WHO publications issued in 1980 on subjects relating to health manpower development:

F. M. Katz & R. Snow. Assessing health workers' performance: a manual for training and supervision (Public Health Papers, No. 72)

The primary health worker: working guide, guidelines for training, guidelines for adaptation (revised ed.)

P. Hornby et al. Guidelines for health manpower planning

On being in charge: a guide for middle-level management in primary health care

Programme development and support

207. Managerial processes for national health development. In the African Region, an interministerial conference on the planning and management of health services was held in Dakar in April with the participation of the Ministers of Health and of Economic Planning of Benin, Mali, Mauritania and Senegal.

208. The first regional consultation on the development of management training was held in Arusha, United Republic of Tanzania, in July. The objective of the meeting was to promote and strengthen health management training in the African Region through the establishment of national networks of institutions in order to develop national health management capacities for the attainment of health for all by the year 2000. Participants came from health and management training institutions and from ministries of health and social welfare in many countries of the Region. Prior to the meeting, questionnaires were sent out to determine the management procedures at present being taught in some institutions in Africa, so that these procedures could be reviewed at the meeting together with those used by ministries and WHO. The relevance of existing courses to the goal of health for all by the year 2000 was discussed, together with ways in which existing training programmes at all levels could be strengthened. It is hoped, for instance, that health management training opportunities may be established in institutions which have not so far offered them.

209. Among the recommendations of the consultation were that WHO should establish an African network of health management development programmes and prepare an up-to-date inventory of health management programmes in the African Region and make it available to all Member States and institutions in the Region; the working document on national health management processes should be amended, published and distributed to governments and health management institutions in the Region; and teaching modules on the health management process should be prepared and distributed to all training institutions. Recommendations were also made for action by health management development institutions and ministries of health in the Region.

210. In October-November an intercountry workshop on country health programming was organized in the African Region, attended by 30 participants from English-speaking countries, a similar workshop for French-speaking nationals having been held late in 1979. Training workshops concerned with country health programming were held during the year in Namibia (16 participants), Rwanda (29) and Zanzibar, United Republic of Tanzania (26).

211. PAHO/WHO, in support of the existing network of 49 regular courses in health care administration in the Region of the Americas, initiated the implementation of a new phase of its programme in health administration with the support of the W. K. Kellogg Foundation. The main purpose of this programme is the strengthening of health care administration as a means to improve the health of the people in the Region. Three areas of interest were developed in 1980, through the preparation of literature and workshops, as the strategy to improve the educational process and content of courses: teaching of economics and finance,

teaching of organizational behaviour, and teaching of health assessment and planning. The institutions participating in the process were the Regional Library of Medicine and the Health Sciences, the Latin American Center of Educational Technology for Health, the London School of Hygiene and Tropical Medicine, and Case Western Reserve University. Also in the Region of the Americas, two further important activities were initiated in the field of training in health planning, management and administration: an advanced programme in health administration education for the Central American countries, and an international course on planning for the development of health services systems at the School of Public Health, Mexico City.

212. Three countries of the South-East Asia Region - Burma, India and Sri Lanka - participated in a study to develop training programmes aimed at improving manpower management of primary health care personnel. Burma undertook a systems analysis of the management problems of the primary health care programme and, based on this analysis, began developing a training programme for all levels of managers of primary health care services. India and Sri Lanka initiated the development of similar programmes.

213. In Thailand, the National Economic and Social Development Board established a macro-social development subcommittee with three task forces concerned with health, education and culture, and social welfare and security. The subcommittee, involving five ministries, requested guidelines from the Development Board, which formulated long-range targets and strategies and indicated the mechanisms for achieving them through a long-term (20-year) development plan. To cover the first five years (1982-1986) there is a national social development project. The task forces mentioned above will devise medium-term plans for the five years. The objectives, established initially on the basis of an analysis of past development trends, will be refined with experience. Indicators will be selected and specified in terms of targets to be agreed by all the agencies concerned. Progress will be monitored throughout the five-year period and evaluated before the next five-year planning cycle commences. For the achievement of objectives and targets, fundamental strategies and supportive strategies will be identified for the main sectoral areas. Future resources will be estimated and service delivery will be planned accordingly. This broad approach is well in line with WHO's recommendations, and progress in Thailand will be watched with great interest by many Member countries.

214. The first workshop on the strengthening of health management in the Eastern Mediterranean Region was held in Mogadishu in September, with participants from Democratic Yemen (2), Somalia (19), Sudan (2), and Yemen (1). The emphasis was on training in health management needs, and use was made of local case material and other learning materials adapted to the requirements of the participants and countries concerned.

215. Countries of the Western Pacific Region made use of managerial processes in the context of updating policies and strategies to support primary health care and attain health for all. For instance, the country health programming process was used in Fiji, Papua New Guinea and Samoa. Malaysia, Solomon Islands, Tonga and the Trust Territory of the Pacific Islands developed new five-year health development plans. The Philippines developed an organizational strategy for achieving health for all. WHO provided support for the Department of Health of Samoa in planning and conducting a middle-level management workshop for staff of the Department. Initial preparations were made for establishing a network of national health development centres in the Region. In collaboration with the University of the South Pacific, a short course in hospital administration for middle-level nonmedical administrators, funded by UNDP, was held in Suva. Training in hospital administration was strengthened in the Philippines and in the Republic of Korea.

216. In 1980 WHO completed the formulation of a strategy aimed at supporting Member States in developing and applying an integrated managerial process for national health development. The components of the strategy include: promotion, technical cooperation, training, further development of methodology, and strengthening of WHO's support capacity. Global and regional plans are in preparation to give effect to this strategy.

217. Guiding principles, intended for adaptation by countries, on managerial processes for national health development were finalized in 1980 after several years of preparation. They will be published in 1981 in a new WHO series entitled "Health for All", as follows:[1]

No. 3. Global Strategy for health for all by the year 2000.

No. 4. Development of indicators for monitoring progress towards health for all by the year 2000.

No. 5. Managerial process for national health development: Guiding principles.

218. Health information. Only a small number of the 800 biomedical journals published in Latin America are included in existing international indexing and retrieval services, so that a considerable amount of valid information never reaches health workers. This situation prevents the necessary exchange of information between developing countries with similar health problems. The new Index Medicus Latino Americano, prepared and published by the PAHO/WHO Regional Medical Library in São Paulo, Brazil, constitutes the first serious attempt to cope with this problem. With the aid of a minicomputer provided by the Government of Brazil, and with the use of a translation of the indexing rules of the original Index Medicus, nearly 200 journal titles are now being published and analysed. This collaborative effort between the United States National Library of Medicine, PAHO/WHO, the Brazilian Government and the health authorities of Latin American countries is a noteworthy example of what can be done within the framework of the concept of TCDC.

219. A serious obstacle to the development of water supply and sanitation programmes in the Caribbean and in Latin America is the lack of services for the transfer of technical information. The need to overcome this obstacle is urgent if all available technologies are to be employed in achieving the goals of the International Drinking Water Supply and Sanitation Decade. In 1980 a master plan for a regional information and documentation network on sanitary engineering and environmental sciences, sponsored by PAHO/WHO through the Pan American Center for Sanitary Engineering and Environmental Sciences, was approved and entered on a phase of pilot operation, testing and evaluation, with the support of the International Development Research Centre in Canada. The focus is on the development and coordination of a network of collaborating national information centres, including the International Reference Centre in The Hague. The network currently consists of five national focal points. When in full operation, with 12-15 such centres, the system will, in keeping with the principles of technical cooperation among developing countries, constitute a national information infrastructure at the service of environmental engineers and scientists, research workers, teachers, designers, managers, technicians, operators and community developers working with water supply and public health agencies throughout the Caribbean and Latin America.

220. Emergency relief operations. Health agencies should assume a responsible role in the relief work after a natural disaster. They should also be involved in the planning and siting of water supply and sewerage facilities so as to minimize the disruption of services. They should assist responsible agencies in the preparation of contingency plans in case of accidental "spills" of toxic and hazardous substances. These contingency plans should be made known widely. These were among the recommendations of a WHO seminar on emergency assistance in environmental health, held in Manila in January and attended by 20 officials from 17 Western Pacific countries. The meeting concluded that although the health agencies in most WHO Member States conduct environmental health programmes, they are not at present involved in the planning, zoning and siting of facilities in accordance with environmental

[1] No. 1 and No. 2 in the series were originally issued as nonserial publications in 1978 and 1979 respectively, but have now been incorporated into the series:

No. 1. Alma-Ata 1978: Primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

No. 2. Formulating strategies for health for all by the year 2000.

protection needs. Many countries do not have adequate legislation or regulations for the proper control of toxic and hazardous substances. The increasing use of hazardous chemicals in agriculture, industry and in the home makes it important to plan and control the manufacture, storage, transport and use of such chemicals. There is also an increased potential for accidental release of these substances into the environment which may cause harm to people and property. The meeting recommended short training courses or on-the-job training for personnel in the planning and execution of preventive and protective measures against disasters.

221. During 1980, as in the past, WHO participated fully in the provision of emergency relief by the United Nations system, its work being carried out in close collaboration with agencies and other institutions and nongovernmental organizations active in disaster work. Epidemics in Africa, hurricanes in the Americas, the plight of refugees in South-East Asia, earthquakes in Europe - these and other circumstances and events made particularly heavy demands on WHO's resources. During 1980 the Organization undertook 52 separate new emergency actions and mobilized over US$ 9.5 million from extrabudgetary sources for this purpose.

222. To quote one example from the European Region, the sum of US$ 25 000 was made available to the Algerian Government after the earthquake in El Asnam in October. It was used to provide supplies such as vaccines and spraying and injection equipment for health centres, and to finance visits to the site of the disaster by WHO staff and European experts. WHO sanitary engineers were immediately sent to El Asnam to take part in the rescue operations and to advise on provisional basic sanitation facilities and the repair of the water supply system.

223. Also in collaboration with other organizations of the United Nations system, WHO undertook urgent health measures on behalf of national liberation movements recognized by OAU, which are struggling to maintain acceptable levels of health and social conditions under extremely difficult circumstances.

Conclusion

224. Having started with the strategies for health for all that were designed by Member States during 1980, this report ends as it began - with action in countries. That is where the impact of WHO's activities has to be felt in the final assessment of WHO's usefulness. Based on national experience, regional and global policies and programmes have to be defined, but these have to focus in turn on support to national health endeavours. WHO has shown that it is capable of crystallizing regional and worldwide health policies and of defining strategies for their implementation that have all the potential for leading to radical improvements in the health situation of all its Member States. It is up to these Member States to use their WHO fully to this end, and in so doing to convert it into the WHO they deserve.

Appendix

A SELECTION OF MEASURES TAKEN IN VARIOUS COUNTRIES RELATED TO THE THEME OF WORLD HEALTH DAY 1980: SMOKING OR HEALTH - THE CHOICE IS YOURS[1]

Austria. In accordance with an informal agreement between the Ministry of Health and the tobacco companies, the nicotine and tar content of cigarettes must be indicated on packages. Tobacco advertising on radio and television has been prohibited by law; and tobacco advertising in other media, particularly those likely to influence young people, has been severely restricted.

Bahrain. Tobacco advertising is banned on radio and television, and smoking is prohibited in schools, clubs, and health centres, as well as at meetings held by the Ministry of Health.

[1] This selection is in no way complete, nor does it attempt to give an adequate representation of all regions of the world; it merely reflects some recent trends. Sources of information include statements made by delegates to the World Health Assembly in May and communications from governments and nongovernmental organizations.

Bangladesh. A national anti-smoking advisory group has been set up, which will submit a report to the Ministry of Health and Population Control on measures that might be taken to curb the smoking habit.

Belgium. Cigarette vending machines have been prohibited, as well as free distribution. Health warnings in French and Flemish must be printed on cigarette packets. Cinema, radio and television advertisements have been banned, as have advertisements in publications for children. It is forbidden for tobacco companies to sponsor sports events and competitions.

Brazil. The tax on the sale of cigarettes is now higher than that on any other consumer product, providing 12% of the overall federal tax yield. A national anti-smoking programme has been established, and smoking has been banned in all offices of the health secretariat.

Bulgaria. Doctors have been urged to give up smoking to set an example, and smoking has been banned in areas where pregnant women and nursing mothers are present, as well as in airports, railway and bus stations, railway carriages, aircraft where the flight does not exceed two hours, in rest and eating areas in factories, institutions such as schools, youth hostels and youth clubs, and in restaurants, except for specially designated areas.

Canada. Although 57% of Canadians over 15 years of age do not smoke, more teenage girls are smoking. A nationwide "Weedless Wednesday" is staged each year to alert the public to the smoking hazard. The Fifth World Conference on Smoking and Health will be held in Winnipeg in 1983.

China. A major anti-smoking campaign has been launched, with the support of the Vice-Minister of Public Health.

Denmark. A Ministry of Health circular advised the provision of non-smoking rooms for patients in hospitals, forbade smoking in waiting rooms, and recommended that health personnel in contact with patients should not smoke.

Egypt. An anti-smoking publicity campaign has been stepped up, including efforts to persuade cigarette manufacturers to reduce the tar and nicotine content of their products. There is no mass media advertising of tobacco.

Finland. A comprehensive approach has been adopted, involving health education, legislation, and research into the effects of smoking on health. A total ban on tobacco advertising has been imposed, and smoking has been restricted in public places. These measures have led to a continuing decrease in smoking among men and teenagers. There is now a demand for even more restrictions on smoking at workplaces, and initiatives are being developed with the trade unions. The Tobacco Act provides that 0.5% of tobacco tax revenue must be spent on anti-smoking publicity.

France. The Ministry of Health launched a nationwide programme. 7 April (World Health Day) was the day of the "petite fleur", when French people were invited to give up tobacco for 24 hours at least. Nine million special stamps were issued; a vast range of public information activities included twenty 30-second items on the major television networks, and the issue of one million copies of brochures and printed information.

Federal Republic of Germany. A private health education organization, the German Green Cross, distributed millions of brochures and thousands of displays on the theme of World Health Day. The Federal Government's television channel presented a variety of programmes in some of which people were invited to participate in courses to share their personal experiences and give up smoking.

Greece. Smoking has been banned in cinemas, theatres, hospitals and clinics, and public transport. It is a punishable offence to smoke in all indoor public places. The Ministry of Health is organizing a broad educational campaign to further the decline of smoking.

Iraq. Tobacco has been banned in schools and universities and, during working hours, in all medical establishments and at meetings in State ministries. Tobacco can no longer be

advertised in the press or on television, and cigarette packets must carry a health warning. Iraqi Airlines is being encouraged not to sell tobacco on its aircraft. Action has been taken to limit, and gradually reduce, the area of land under tobacco cultivation.

Ireland. The campaign against smoking has been stepped up. A cigarette packet called Conquest contains, instead of cigarettes, 30 cards on how to give up the habit; it is distributed free through chemists.

Italy. A National Committee for the Fight Against Smoking has been set up at the Ministry of Health.

Japan. The Japan Scholars' Association on Circulatory Organs proclaimed 1980 the year to give up smoking.

Kenya. To coincide with World Health Day, a sweeping ban was imposed on smoking on public transport and in theatres and hospitals.

Kuwait. The first legislation against tobacco advertising has been passed.

Malaysia. The country is increasingly concerned about smoking, as the annual per capita cigarette consumption for the population over 15 years of age is about 2000, and increasing at the rate of around 7% annually; more money is spent on advertising tobacco than on any other form of advertising (about 9% of total advertising expenditure).

Netherlands. Legislative measures have been taken to protect the atmosphere in public places: smoking has been prohibited in government schools, cinemas, department stores, theatres, trains and buses. Tobacco advertising in the mass media has been banned, and an intensive campaign to discourage smoking is gaining momentum.

New Zealand. World Health Day, designated as a smoke-free day, served as a launching pad for other anti-smoking activities and was fully supported by the media. A voluntary agreement between the Ministry of Health and the tobacco companies was renegotiated, covering the inclusion of a more strongly worded warning notice and the tar range in advertisements, further restrictions on advertising, particularly at the point of sale, and monitoring of the agreement by the news media's Committee on Advertising Practice.

Nigeria. The tobacco industry in Nigeria, although helping farmers by encouraging crop diversification, has launched massive marketing campaigns. The medical profession, however, is beginning extensive educational campaigns.

Papua New Guinea. The World Health Day theme stimulated the Ministry for Health to consider introducing legislation to reduce and control tar and nicotine in cigarettes made and distributed in Papua New Guinea. Cigarette manufacturers agreed to discuss this matter.

Poland. The number of smokers is now roughly twice as high as in 1955, and the smoking habit is spreading, particularly among women and young people. The World Health Day theme encouraged measures to implement the World Health Assembly resolution on smoking and health.

Portugal. An anti-smoking campaign was held in conjunction with World Health Day, and a national interministerial commission has been set up to formulate a national plan to control the rising number of smokers.

Saudi Arabia. Tobacco advertising has been banned in the press, radio and television, and action is being taken to ban smoking in educational establishments. Smoking is prohibited in the Ministry of Health and its hospitals.

Singapore. An all-out campaign against smoking has been mounted, linked to several diseases related to lifestyle (smoking and overeating). Advertising has been banned in all the media. Laws are being drafted to enforce the printing of warnings on cigarette packets.

Sri Lanka. Action has been taken to ban all advertisements for smoking, smoking in public places and transport has been forbidden, and it is now obligatory for cigarette packets to carry a health warning.

Sweden. Cigarette packets must carry one of at least 16 different warnings, to ensure that the smoker does not become accustomed to the same message.

United Arab Emirates. Tobacco advertising is banned on national radio and television and in official newspapers. Smoking is prohibited in cinemas and educational establishments. Anti-smoking information programmes are under way.

United Kingdom of Great Britain and Northern Ireland. Discussions are continuing between the Department of Health and Social Security and the tobacco industry to modify and update the present voluntary agreement on the advertising and promotion of tobacco. Particularly controversial is the sponsorship of sports activities by the tobacco companies.

United Republic of Cameroon. The theme "Smoking or health - the choice is yours" had a great impact. Prior to the campaign, even many medical staff seemed unaware of the dangers of smoking.

United States of America. There are still an estimated 350 000 deaths a year due to smoking, but significant gains have been made since 1974, when 42% of adults smoked. The current rate is 34%, meaning that 30 million smokers have successfully given up the habit and millions more have not started. However, more girls are smoking each year. Each year the American Cancer Society holds the Great American Smokeout, to help make Americans aware of smoking risks.

Union of Soviet Socialist Republics. Nationwide propaganda campaigns are under way. A striking success is Sochi, a Black Sea resort, which is a non-smoking city: cigarettes are banned from beaches, restaurants, offices, public and private transportation, and schools and hospitals.

MEMBERSHIP OF THE HEALTH ASSEMBLY

LIST OF DELEGATES AND OTHER PARTICIPANTS

DELEGATIONS OF MEMBER STATES

AFGHANISTAN

Delegates

Dr N. KAMYAR, Second Deputy Minister of Public Health (Chief Delegate)

Dr S. AHMAD, Associate Professor of Preventive and Social Medicine, University of Kabul

ALBANIA

Delegates

Professor J. PULO, Vice-Minister of Public Health (Chief Delegate)

Dr Z. ESHJA, Director, Obstetrical and Gynaecological Hospital of Tirana, Ministry of Public Health

ALGERIA

Delegates

Mr A. BOUHARA, Minister of Public Health (Chief Delegate)

Mr M. BOUGARA, Secretary-General, Ministry of Public Health[1]

Mr M. I. MADANY, Director of External Relations, Ministry of Public Health

Alternate

Professor D. MAMMERI, Technical Adviser responsible for International Relations, Office of the Minister of Public Health

Advisers

Professor M. M. BENHASSINE, Director-General, Pasteur Institute of Algeria

Mr M. S. BABES, Director-General of Social Security, Ministry of Public Health

Dr Z. OUARTSI, Director of Family Health Protection and Health Education, Ministry of Public Health

Mr A. SAYAD, Technical Adviser, Office of the Minister of Public Health

Professor M. KOUIDRI, Director of Training, Ministry of Public Health

Dr B. HADJ-LAKEHAL, Director of Preventive Services, National Institute of Public Health

Professor A. ZIARI, Director, Institute of Medical Sciences, Algiers

Mr R. TEMIMI, Director of Medical Teaching Affairs

Mr Y. BRIKI, Minister Plenipotentiary, Permanent Mission of the Democratic People's Republic of Algeria to the United Nations Office at Geneva and the Specialized Agencies in Switzerland and Austria

Mr Y. SELLAL, Chargé de Mission, Ministry of Public Health

Miss H. TOUATI, Ministry of Foreign Affairs

ANGOLA

Delegates

Mr A. A. MENDES DE CARVALHO, Minister of Health (Chief Delegate)

Dr F. J. FERNANDES, Vice-Minister of Health

Dr U. FRESTA, Director, Technical Office, Ministry of Health

Alternates

Dr L. G. SAMBO, Provincial Public Health Delegate, Ministry of Health

Dr C. A. SILVA LOPES, Professor, Faculty of Medicine, University of Angola

Dr E. CHITONHO EFRAÍM, Provincial Public Health Delegate (Quanza-Sul), Ministry of Health

[1] Chief Delegate from 14 May.

Mrs M. O. TORRES, National Directorate of Administrative Training, Ministry of Health

ARGENTINA

Delegates

Dr A. ARGÜELLES, Minister of Public Health and Environment (Chief Delegate)

Dr R. R. RODRÍGUEZ, Under-Secretary for Health Personnel Training and Research, Ministry of Public Health and Environment

Mr G. O. MARTÍNEZ, Ambassador, Permanent Representative of the Republic of Argentina to the United Nations Office and the Other International Organizations at Geneva

Alternates

Mr F. JIMÉNEZ DÁVILA, Ambassador, Deputy Permanent Representative of the Republic of Argentina to the United Nations Office and the Other International Organizations at Geneva

Mr E. G. BONNET MURRAY, Chef de cabinet to the Minister of Public Health and Environment

Advisers

Mr V. BEAUGE, Minister, Permanent Mission of the Republic of Argentina to the United Nations Office and the Other International Organizations at Geneva

Mr A. L. DAVÉRÈDE, Counsellor of Embassy, Permanent Mission of the Republic of Argentina to the United Nations Office and the Other International Organizations at Geneva

Miss N. NASCIMBENE, Second Secretary, Permanent Mission of the Republic of Argentina to the United Nations Office and the Other International Organizations at Geneva

AUSTRALIA

Delegates

Dr G. HOWELLS, Director General of Health, Department of Health (Chief Delegate)

Dr D. BOOTH, Assistant Director General, Department of Health (International Health and Tuberculosis Branch) (Deputy Chief Delegate)[1]

[1] Chief Delegate from 15 May.

Dr L. D. THOMSON, Ambassador, Permanent Representative of Australia to the United Nations Office and the Other International Organizations at Geneva[2]

Alternates

Dr H. C. ANDERSON, Regional Medical Director, Migration Office, Australian Embassy in Italy

Mr K. WIDDOWS, First Secretary, Permanent Mission of Australia to the United Nations Office and the Other International Organizations at Geneva

Adviser

Mr R. E. STENSHOLT, Counsellor, Australian Embassy in Italy

AUSTRIA

Delegates

Dr K. STEYRER, Federal Minister of Health and Environmental Protection (Chief Delegate)

Dr J. DAIMER, Deputy Director-General of Public Health, Federal Ministry of Health and Environmental Protection[3]

Dr R. HAVLASEK, Director-General, Federal Ministry of Health and Environmental Protection

Alternates

Professor V. H. HAVLOVIC, Director, Federal Ministry of Health and Environmental Protection

Dr E. FRITZ, Federal Ministry of Health and Environmental Protection

Mr E. NETTEL, Ambassador, Permanent Representative of Austria to the United Nations Office and the Specialized Agencies at Geneva

Dr W. LANG, Counsellor, Deputy Permanent Representative of Austria to the United Nations Office and the Specialized Agencies at Geneva

Mr W. HOWADT, Second Secretary, Permanent Mission of Austria to the United Nations Office and the Specialized Agencies at Geneva

BAHAMAS

Delegate

Mrs V. F. BROWN, First Assistant Secretary, Ministry of Health and National Insurance

[2] Deputy Chief Delegate from 15 May.

[3] Chief Delegate from 7 May.

BAHRAIN

Delegates

Dr A. M. FAKHRO, Minister of Health (Chief Delegate)

Dr E. YACOUB, Assistant Under-Secretary for Primary and Preventive Medicine, Ministry of Health (Deputy Chief Delegate)

Dr A. F. ABOU ZAID, Director General of Curative Medicine, Ministry of Health

Alternate

Mr F. MASKATI, Assistant Administrator, Sulmania Medical Centre

BANGLADESH

Delegates

Dr F. KARIM, Minister of State for 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

Mr A. M. H. HUSSAIN, Secretary, Ministry of Health and Population Control

Alternates

Professor M. A. HALEEM, Additional Secretary, Ministry of Health and Population Control

Mr N. CHOWDHURY, Second Secretary, Permanent Mission of the People's Republic of Bangladesh to the United Nations Office and Other International Organizations at Geneva

BELGIUM

Delegates

Mr L. DHOORE, Minister of Social Welfare and Public Health (Chief Delegate)

Professor S. HALTER, Secretary-General, Ministry of Public Health and Family Welfare (Deputy Chief Delegate)[1]

Mr A. ONKELINX, Ambassador, Permanent Representative of Belgium to the United Nations Office and the Specialized Agencies at Geneva[2]

Alternates

Mr A. BERWAERTS, Inspector and Head of Section, Ministry of Public Health and Family Welfare[3]

Dr J. BURKE, 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

Miss G. VAN DEN BERGH, Attaché, Permanent Mission of Belgium to the United Nations Office and the Specialized Agencies at Geneva

Advisers

Professor R. F. BECKERS, Director General, Ministry of Public Health and Family Welfare

Dr J. E. E. G. DEROY, Director General, Ministry of Public Health and Family Welfare

Dr P. DE SCHOUWER, Chef de Cabinet of the Minister of Public Health

Dr J. FRANCOIS, Director General, Ministry of Public Health and Family Welfare

Dr M. KIVITS, Administrator and Secretary, Tropical Medicine Fund

Professor K. VUYLSTEEK, Faculty of Medicine, University of Ghent

Professor M. F. LECHAT, School of Public Health, Catholic University of Louvain

Professor Gilberte Marie REGINSTER, Institute of Hygiene and Social Medicine, University of Liège

Professor L. EYCKMANS, Director, Prince Leopold Institute of Tropical Medicine, Antwerp

Professor E. A. SAND, School of Public Health, Free University of Brussels

Professor F. BARO, Faculty of Medicine, Catholic University of Louvain

Professor R. MENDLEWICZ, Faculty of Medicine, Free University of Brussels

Professor C. H. THILLY, School of Public Health, Free University of Brussels

Professor W. J. EYLENBOSCH, Section of Epidemiology and Social Medicine, University of Antwerp

Mr J. ORENBUCH, Research group director, Free University of Brussels

BENIN

Delegates

Mr P. KPOFFON, Minister of Public Health (Chief Delegate)

[1] Chief Delegate from 7 May.

[2] Deputy Chief Delegate from 7 May.

[3] Delegate from 7 May.

Professor B.-C. SADELER, Director, Institute of Applied Biomedical Sciences[1]

BOLIVIA

Delegates

Dr A. SAAVEDRA WEISE, Ambassador, Permanent Representative of the Republic of Bolivia to the United Nations Office and the Other International Organizations at Geneva (Chief Delegate)

Mr A. ARGUEDAS, Minister Counsellor, Deputy Permanent Representative of the Republic of Bolivia to the United Nations Office and the Other International Organizations at Geneva

Miss M. LAPEYRIÈRE SUÁREZ, 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. MAKHWADE, Director of Nursing Services, Ministry of Health

BRAZIL

Delegates

Dr W. MENDES ARCOVERDE, Minister of Health (Chief Delegate)

Dr E. P. F. BRAGA, Vice-President, Oswaldo Cruz Foundation; Director, National School of Public Health (Deputy Chief Delegate)

Mrs V. RUMJANEK CHAVES, Coordinator of International Affairs, Ministry of Health

Alternates

Mr G. MOSTARDEIRO BONOW, Secretary for Health and Environment, State of Rio Grande do Sul

Mr F. CUMPLIDO, Minister for Commercial Affairs, Permanent Mission of Brazil to the United Nations Office and the Other International Organizations at Geneva

Mr G. VERGNE SABOIA, Counsellor, Permanent Mission of Brazil to the United Nations Office and the Other International Organizations at Geneva

Mr L. A. FIGUEIREDO MACHADO, Third Secretary, Ministry of Foreign Affairs

Dr M. G. CANDAU, Attaché for Scientific Affairs, Permanent Mission of Brazil to the United Nations Office and the Other International Organizations at Geneva

Dr E. SOARES, Permanent Mission of Brazil to the United Nations Office and the Other International Organizations at Geneva

Advisers

Dr M. B. BELCHIOR, President, Federal Council of Medicine

Dr E. SANTA CRUZ DE OLIVEIRA, President of the Society of Geriatrics of Brasilia

BULGARIA

Delegates

Professor K. GARGOV, Deputy Minister of Public Health (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 (Deputy Chief Delegate)

Mr P. GROZDANOV, Second Secretary, Ministry of Foreign Affairs

Alternates

Dr D. KRUSHKOV, Director, Department of International Relations, Ministry of Public Health

Professor K. ICHEV, Deputy Chancellor, Medical Academy of Sofia

Dr M. MILEV, Principal Secretary, Ministry of Public Health

Dr K. CHAMOV, Research Attaché, Institute of Social Hygiene and Public Health Organization

[1] Chief Delegate from 14 May.

BURMA

Delegates

Dr WIN MAUNG, Minister of Health (Chief Delegate)
Dr KYAW MAUNG, Director-General, Department of Health (Deputy Chief Delegate)
Dr MAUNG KYAW, Deputy Director for Medical Care, Department of Health

Alternates

Dr KHIN MAUNG KYWE, Assistant Director (Health Statistics), Department of Health
Mr MYA LWIN, Personal Assistant to the Minister of Health
Mr THAN TUN, Second Secretary, Permanent Mission of the Socialist Republic of the Union of Burma to the United Nations Office and Other International Organizations at Geneva

BURUNDI

Delegates

Dr P. MPITABAKANA, Director-General of Public Health (Chief Delegate)
Mr A. BAZA, Director, Department of Health Logistics, Ministry of Public Health
Dr P. NDIKUMANA, Ministry of Public Health

Advisers

Mr T. N. SANZE, Ambassador, Permanent Representative of the Republic of Burundi to the United Nations Office and the Specialized Agencies at Geneva
Mr B. SEBURYAMO, First Counsellor, Permanent Mission of the Republic of Burundi to the United Nations Office and the Specialized Agencies at Geneva

CANADA

Delegates

Mme M. BÉGIN, Minister of Health and Welfare (Chief Delegate)
Mr D. S. McPHAIL, Ambassador, Permanent Representative of Canada to the Office of the United Nations and the Other International Organizations at Geneva
Dr Maureen M. LAW, Assistant Deputy Minister, Health Services and Promotion Branch, Department of National Health and Welfare[1]

Alternates

Mr W. K. MORRISSEY, Deputy Minister of Health, Province of New Brunswick
Mr K. FYKE, Deputy Minister of Health Province of Saskatchewan
Dr L. BLACK, Assistant Deputy Minister, Medical Services 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
Dr C. W. L. JEANES, Chief, Health and Population Resources Branch, Canadian International Development Agency
Mr M. CAREAU, Senior Adviser, Intergovernmental and International Affairs Branch, Department of National Health and Welfare

Advisers

Mr C. SIROIS, First Secretary, Permanent Mission of Canada to the United Nations Office and the Other International Organizations at Geneva
Dr J.-P. FORTIN, Director, Community Health and Native Community Services, Department of Social Affairs, Province of Quebec
Mrs L. A. LEFEBVRE, Bureau of United Nations Affairs, Department of External Affairs

CAPE VERDE

Delegates

Dr I. F. BRITO GOMES, Minister of Health and Social Affairs (Chief Delegate)
Dr A. D. FERMINO PINA, Director, Maternal and Child Health and Family Planning Project
Dr D. DANTAS DOS REIS, Director, Clinic of the Central Hospital of Praia

[1] Chief Delegate from 9 May.

CENTRAL AFRICAN REPUBLIC

Delegates

Mr A. BOUKANGA, Minister of Health and Population (Chief Delegate)

Mr M. GBEZERA-BRIA, Ambassador, Permanent Representative of the Central African Republic to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Dr D. KPOSSA-MAMADOU, Director-General of Health and Population

Alternates

Professor G. PINERD, National WHO Programme Coordinator

Mr M. SONGODET-KYRIOS, First Counsellor, Permanent Mission of the Central African Republic to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Mr T. NZEKEBALOUDOU, Attaché (Administrative Affairs), Permanent Mission of the Central African Republic to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

CHAD

Delegates

Dr D. DJEKOUNDADÉ, Director of Rural and Preventive Medicine, Ministry of Public Health and Social Affairs (Chief Delegate)

Mr E. NADJIB, Agent technique, Ministry of Public Health and Social Affairs

CHILE

Delegates

Mr H. RIVERA, Minister of Health (Chief Delegate)

Dr G. DELGADO, Adviser to the Minister of Health

Dr J. M. BORGOÑO, Chief, Department of Public Health, Ministry of Health

Alternate

Dr J. GIACONI, Director of Planning, Ministry of Health

Advisers

Mr C. BUSTOS, Minister Counsellor, Deputy Permanent Representative of Chile to the United Nations Office at Geneva and the Other International Organizations in Switzerland

Mr R. PLAZA, Counsellor, Permanent Mission of Chile to the United Nations Office at Geneva and the Other International Organizations in Switzerland

CHINA

Delegates

Dr QIAN Xinzhong, 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 LIANG Jimin, Deputy Director, General Office, Ministry of Public Health

Professor LU Rushan, Vice-President, Branch of Chinese Academy of Medical Sciences

Mr LI Zhangqi, Counsellor, Deputy Permanent Representative of the People's Republic of China to the United Nations Office at Geneva and the Other International Organizations in Switzerland

Dr LIU Xirong, Chief, Division of International Organizations, Bureau of Foreign Affairs, Ministry of Public Health

Advisers

Mr DU Zhongyin, 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

Mrs MAO Yueming, Department of International Organizations, Ministry of Foreign Affairs

Mr HAO Shouyi, Bureau of Foreign Affairs, Ministry of Public Health

Mr CAO Yonglin, Bureau of Foreign Affairs, Ministry of Public Health

Mr CHEN Fuqing, 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

COLOMBIA

Delegates

Dr A. JARAMILLO, Minister of Health (Chief Delegate)

Dr E. GUERRERO, Director of Medical Care Services, Ministry of Health

Mr G. VARGAS, Chief, Legal Office, Ministry of Health

Alternates

Dr L. PONTON, Chief, Division of Bilateral and Regional Agreements, Ministry of Health

Mrs B. M. DE ALVAREZ, First Secretary, Permanent Mission of Colombia to the United Nations Office and the Specialized Agencies at Geneva

COMOROS

Delegates

Mr S. A. MOHAMED, Minister of Public Health, Population, and Islamic Affairs (Chief Delegate)

Dr Y. M'DAHOMA SOILIHI, Director-General of Public Health, Ministry of Public Health

Mr S. O. BEN ACHIRAFI, Chief, Planning, Budget and Administration Section, Ministry of Public Health

CONGO

Delegates

Mr P.-D. BOUSSOUKOU-BOUMBA, Minister of Health and Social Affairs (Chief Delegate)

Dr B. LOEMBE, Director-General of Health, Ministry of Health and Social Affairs

Mr E. MBALOULA, Director of Planning and Statistics, Ministry of Health and Social Affairs

Alternate

Dr G. ONDAYE, National WHO Programme Coordinator

COSTA RICA

Delegates

Dr C. CALVOSA CHACÓN, Minister of Health (Chief Delegate)

Dr L. MARRANGHELLO BONIFATI, Deputy Director-General of Health, Ministry of Health

Dr C. CASTRO-CHARPENTIER, Assistant Director, Social Security Fund

Alternate

Mrs M. E. ODIO-BENITO, Deputy Permanent Representative of the Republic of Costa Rica to the United Nations Office and the Other International Organizations at Geneva

CUBA

Delegates

Dr J. ALDEREGUÍA, Vice-Minister of Public Health (Chief Delegate)

Mr A. ZORRILLA, Director of International Relations, Ministry of Public Health (Deputy Chief Delegate)

Mr L. SOLÁ VILA, Ambassador, Permanent Representative of the Republic of Cuba to the United Nations Office at Geneva and the Other International Organizations in Switzerland

Alternates

Professor L. ARAUJO, Higher Institute of Medical Sciences, Havana; Adviser to the Ministry of Public Health

Mrs A. M. LUETTGEN, International Organizations Division, Ministry of External Relations

Mr J. A. PAGÉS PIÑEIRO, Adviser on International Organization Affairs, Ministry of Public Health

Mr J. SIVILA DE LA TORRE, Second Secretary, Permanent Mission of the Republic of Cuba to the United Nations Office at Geneva and the Other International Organizations in Switzerland

Mrs T. GARCÍA, Directorate of Special Conferences and Non-Aligned Countries, Ministry of External Relations

Mr O. ECHEVARRÍA FIOLS, Ministry of External Relations

CYPRUS

Delegates

Mr G. TOMBAZOS, Minister of Health (Chief Delegate)

Mr C. VAKIS, Director-General, Ministry of Health (Deputy Chief Delegate)

Dr A. MARKIDES, Director of Medical Services, Ministry of Health

Alternates

Mr A. C. POUYOUROS, Ambassador, Permanent Representative of Cyprus to the United Nations Office at Geneva and Specialized Agencies in Switzerland

Mr M. PISSAS, Counsellor, Deputy Permanent Representative of Cyprus to the United Nations Office at Geneva and Specialized Agencies in Switzerland

Dr A. PAPADOPOULOS, Counsellor, Permanent Mission of Cyprus to the United Nations Office at Geneva and Specialized Agencies in Switzerland

CZECHOSLOVAKIA

Delegates

Professor E. MATEJÍČEK, Minister of Health of the Slovak Socialist Republic (Chief Delegate)

Professor J. PROKOPEC, Minister of Health of the Czech 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

Mrs A. PÁROVÁ, Department for International Economic Organizations, Federal Ministry of Foreign Affairs

Mr J. JIRŮŠEK, Third Secretary, Permanent Mission of the Czechoslovak Socialist Republic to the United Nations Office and the Other International Organizations at Geneva

[1] Chief Delegate from 11 May.

DEMOCRATIC KAMPUCHEA

Delegates

Professor THIOUNN THOEUN, Minister of Health (Chief Delegate)

Mr OK SAKUN, Ambassador, Permanent Representative of Democratic Kampuchea to the United Nations Office at Geneva and the Other International Organizations in Switzerland

Mr TE SUN HOA, Counsellor, Deputy Permanent Representative of Democratic Kampuchea to the United Nations Office at Geneva and the Other International Organizations in Switzerland

Alternates

Dr LY BENG CHHEANG, Ministry of Health

Mrs K. THIOUNN, Ministry of Health

DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

Delegates

Mr JIN Chung Kuk, 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 KWON Sung Yon, Department of External Affairs, Ministry of Public Health

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

Alternate

Mr PAK Chang Rim, 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. S. I. BAMATRAF, Deputy Minister of Public Health (Chief Delegate)

Dr A. ABDULLATIF, Director-General of Primary Health Care, Ministry of Public Health

DENMARK

Delegates

Mr H. RASMUSSEN, Minister for the Interior (Chief Delegate)

Dr S. K. SØRENSEN, Director-General, National Board of Health (Deputy Chief Delegate)[1]

Mr J. OSTENFELD, Deputy Permanent Representative of Denmark to the United Nations Office and the Other International Organizations at Geneva

Alternates

Mr H. ODEL, Permanent Secretary, Ministry of the Interior

Mr G. A. LUSTRUP, Deputy Director, Ministry of the Interior[2]

Dr N. ROSDAHL, Deputy Director-General, National Board of Health[3]

Mrs L. E. OLESEN, Head, International Coordination Section, National Board of Health

Mr J. ANDERSEN, Head of section, Ministry of the Interior

Advisers

Dr J. C. SIIM, Director (Technical Affairs), Danish National Serum Institute

Mr P. THORNIT, Private Secretary to the Minister for the Interior

Miss B. POULSEN, Head of section, Ministry of Foreign Affairs

Mr E. LAURIDSEN, Counsellor, Ministry of Foreign Affairs

Mr E. LASSEN, Counsellor, Ministry of Foreign Affairs

Miss M.-L. LAURSEN, Secretary, Permanent Mission of Denmark to the United Nations Office and the Other International Organizations at Geneva

[1] Chief Delegate from 6 to 9 May.

[2] Chief Delegate from 15 to 21 May.

[3] Chief Delegate from 10 to 14 May and on 22 May.

DJIBOUTI

Delegates

Mr M. A. ISSA, Minister of Public Health and Social Affairs (Chief Delegate)

Dr A. ABSIEH, Director of Public Health

Mr I. O. IBRAHIM, Administrator of Peltier Hospital[4]

DOMINICAN REPUBLIC

Delegates

Dr M. VILLANUEVA CALLOT, Ambassador Counsellor, Division of International Organization and Conference Affairs, Secretariat of State for External Relations (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

Mr M.-A. NUÑEZ ARIAS, First Secretary, Permanent Mission of the Dominican Republic to the United Nations Office and the Other International Organizations at Geneva

ECUADOR

Delegates

Mr R. VÁLDEZ, Ambassador, Permanent Representative of the Republic of Ecuador to the United Nations Office at Geneva (Chief Delegate)

Dr F. ANDRADE, Director-General of Health, Ministry of Health

Dr R. SEMPÉRTEGUI, National Director of Health Planning, Ministry of Health

Alternate

Dr M. ALMEIDA, Rural Health Programme Officer, Ministry of Health

EGYPT

Delegates

Dr M. GABR, Minister of Health (Chief Delegate)

Mr A. R. EL REEDY, Ambassador, Permanent Mission of the Arab Republic of Egypt to the United Nations Office and the Specialized Agencies at Geneva (Deputy Chief Delegate)

[4] Chief Delegate from 13 May.

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
Dr A. B. O. MOBARAK, First Under-Secretary of State for Primary Health Care and Family Health, Ministry of Health
Dr R. A. GOMAA, First Under-Secretary of State for the Minister's Office, Ministry of Health
Dr A. A. EL GAMAL, Under-Secretary of State for Curative Medicine, Ministry of Health
Dr A. EL KHOLY, Under-Secretary of State and Secretary-General of the Health Council, Ministry of Health
Dr I. ZAGHLOUL, President, Egyptian Institute for Biological Preparations and Vaccines
Mr I. HASSAN, Counsellor, Permanent Mission of the Arab Republic of Egypt to the United Nations Office and the Specialized Agencies at Geneva
Miss W. BASSIM, Third Secretary, Permanent Mission of the Arab Republic of Egypt to the United Nations Office and the Specialized Agencies at Geneva
Dr Safia IBRAHIM, Director, Poliomyelitis and Rehabilitation Institute
Dr H. TAMMAM, Assistant Director, Maternal and Child Health Department, Ministry of Health
Dr H. A. BELAL, Head of Information and Communication, Ministry of Health

EL SALVADOR

Delegates
Dr G. BELTRÁN CASTRO, Under-Secretary for Public Health and Social Welfare (Chief Delegate)
Mr S. J. TRIGUEROS HIDALGO, Minister Counsellor, Deputy Permanent Representative of the Republic of El Salvador to the United Nations Office and the Other International Organizations at Geneva
Dr J. G. TRABANINO

Adviser
Dr C. A. DÍAZ DEL PINAL, Director of Technical Services, Ministry of Public Health and Social Welfare

EQUATORIAL GUINEA

Delegates
Mr C. SERICHE, Commissioner of State for Health (Chief Delegate)
Mr M. NGUEMA ONGUENE, Technical Secretary, Ministry of Health
Dr D. NSUE-MILANG, Director, Malabo General Hospital

ETHIOPIA

Delegates
Mr W. SAHLU, Permanent Secretary, Ministry of Health (Chief Delegate)
Mr G. A. TEKA, Head, Planning and Programming Office, Ministry of Health (Deputy Chief Delegate)
Mr G. WORKU, Head, Administration Department, Ministry of Health

Adviser
Mr F. YOHANNES, First Secretary, Permanent Mission of Ethiopia to the United Nations Office at Geneva

FIJI

Delegate
Dr M. T. BIUMAIWAI, Permanent Secretary for Health, Ministry of Health

FINLAND

Delegates
Professor E. KIVALO, Director-General, National Board of Health (Chief Delegate)
Dr H. HELLBERG, Director, Primary Health Care Department, National Board of Health
Dr K. LEPPO, Acting Director, Department of Hygiene and Health Promotion, National Board of Health[1]

[1] Chief Delegate from 9 May.

Alternates

Mrs T. MARTIKAINEN, Planning Officer, Ministry for Social Affairs and Health

Mr H. PUURUNEN, Counsellor, Ministry for Foreign Affairs

Mrs T. RAIVIO, Second Secretary (Social Affairs), Permanent Mission of Finland to the United Nations Office and the Other International Organizations at Geneva

FRANCE

Delegates

Professor E. J. AUJALEU, Honorary Director-General, National Institute of Health and Medical Research (Chief Delegate)

Dr Jeanne BROYELLE, Inspector-General, Ministry of Health and Social Security

Dr P. CHARBONNEAU, Honorary Director-General of Health, Ministry of Health and Social Security

Alternates

Dr DETILLEUX, Technical Adviser, Office of the Minister of Health and Social Security

Professor LACRONIQUE, Director, Deputy Director-General of Health and Hospitals, Ministry of Health and Social Security

Dr G. MARTIN, Technical Adviser to the Director-General of Health and Hospitals, Ministry of Health and Social Security

Mr A. NEMO, Embassy 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

Mrs J. DE LA BATUT, Chargé de mission, Ministry of Foreign Affairs

Mr G. PIOLÉ, Attaché, Permanent Mission of France to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

GABON

Delegates

Mr R. MAMIAKA, Minister of State, Minister of Public Health and Population (Chief Delegate)

Dr L. ADANDÉ 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 Services

Alternates

Mr R. AKEREY, Director of the National Pharmacy, Inspector of Pharmacies

Mr A. MANGONGO-NZAMBI, Ambassador, Permanent Representative of the Gabonese Republic to the United Nations Office and the Other International Organizations at Geneva

Mrs R. NGOUYOU, Second Counsellor (Social Affairs and Relations with ILO), Permanent Mission of the Gabonese Republic to the United Nations Office and the Other International Organizations at Geneva

GAMBIA

Delegates

Mr M. C. JALLOW, Minister of Health, Labour and Social Welfare (Chief Delegate)

Mr S. A. NJAI, Permanent Secretary, Ministry of Health, Labour and Social Welfare (Deputy Chief Delegate)

Dr F. S. J. OLDFIELD, Director of Medical Services, Ministry of Health, Labour and Social Welfare

GERMAN DEMOCRATIC REPUBLIC

Delegates

Professor L. MECKLINGER, Minister of Health (Chief Delegate)

Professor K. SPIES, Deputy Minister of Health (Deputy Chief Delegate)[1]

Dr K.-H. LEBENTRAU, Head, Department of International Relations, Ministry of Health

[1] Chief Delegate from 15 May.

Alternates

Dr H. HUYOFF, Senior Lecturer and Senior Physician, Institute of Hygienics, Greifswald University
Mr J. ZENKER, Counsellor, Deputy Permanent Representative of the German Democratic Republic to the United Nations Office and the Other International Organizations at Geneva
Mrs C. WOLF, Second Secretary, International Economic Organizations Division, Ministry of Foreign Affairs
Mr H.-W. MATTERN, Second Secretary, Permanent Mission of the German Democratic Republic to the United Nations Office and the Other International Organizations at Geneva
Dr F. GÖRRES, 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 G. M. FÜLGRAFF, Secretary of State, Federal Ministry for Youth, Family Affairs and Health (Chief Delegate)
Professor L. VON MANGER-KOENIG, Special Consultant on International Health Affairs to the Federal Minister for Youth, Family Affairs and Health (Deputy Chief Delegate) [1]
Dr N. LANG, Minister, Acting Permanent Representative of the Federal Republic of Germany to the Office of the United Nations and the Other International Organizations at Geneva [2]

Alternates

Mr H. VOIGTLÄNDER, Head, International Relations Section, Federal Ministry for Youth, Family Affairs and Health [3]
Mr J. WEITZEL, Counsellor, International Relations Section, Federal Ministry for Youth, Family Affairs and Health
Dr Ruth MATTHEIS, Director, Public Health Department, Berlin (West)
Mr G. BLAUROCK, Counsellor, Permanent Mission of the Federal Republic of Germany to the Office of the United Nations and the Other International Organizations at Geneva
Dr B. ZIESE, Counsellor, Permanent Mission of the Federal Republic of Germany to the Office of the United Nations and the Other International Organizations at Geneva
Dr K. GÖRDEL, Ministerial Counsellor, Head, Section for Health, Nutrition and Population Policy of Developing Countries, Federal Ministry for Economic Cooperation
Dr E. KILLINGER, Counsellor, Section for the United Nations Specialized Organizations and Multilateral Cooperation, Federal Ministry for Economic Cooperation

Advisers

Mrs U. NIEMANN-JORDAN, Counsellor, Section for Health, Nutrition and Population Policy of Developing Countries, Federal Ministry for Economic Cooperation
Dr R. KORTE, Head, Unit for Health, Nutrition and Population Matters, German Agency for Technical Cooperation

GHANA

Delegates

Dr K. OCRAN, Minister of Health (Chief Delegate)
Mr W. A. WILSON, Ambassador, Permanent Representative of the Republic of Ghana to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Dr E. G. BEAUSOLEIL, Director of Medical Services, Ministry of Health

Alternates

Mr I. K. BOATENG, Principal Secretary, Ministry of Health
Dr M. ADIBO, Deputy Director of Medical Services, Ministry of Health
Mr E.-O. VANDERPUIJE, Counsellor, Permanent Mission of the Republic of Ghana to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

GREECE

Delegates

Professor S. DOXIADIS, Minister for Social Services (Chief Delegate)
Dr D. SARFATIS, Director-General of Hygiene, Ministry of Social Services

[1] Chief Delegate from 8 May.

[2] Deputy Chief Delegate from 8 May.

[3] Delegate from 8 May.

Professor D. AVRAMIDIS, School of Public Health, Athens

Alternates

Dr Méropi VIOLAKI-PARASKEVA, Honorary Director-General of Health, Ministry of Social Services

Dr L. LIAROPOULOS, Technical Adviser to the Minister of Social Services

Mr P. APOSTOLIDES, Counsellor, Permanent Mission of Greece to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Miss L. VOURAKIS, Second Secretary, Permanent Mission of Greece to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

GUATEMALA

Delegates

Dr J. R. RECINOS, Minister of Public Health and Social Welfare (Chief Delegate)

Mr C. E. ORANTES-MARTÍNEZ, Minister Counsellor (Economic Affairs), Acting Chargé d'Affaires, Permanent Mission of Guatemala to the United Nations Office and the Specialized Agencies at Geneva (Deputy Chief Delegate)

Dr C. DE PAREDES, Director of Health Planning, Ministry of Public Health and Social Welfare

Alternates

Dr M. R. CALDERÓN PINZON, Division of Epidemiology, General Directorate of Health, Ministry of Public Health and Social Welfare

Mrs N. CONTRERAS, Minister Counsellor, Permanent Mission of Guatemala to the United Nations Office and the Specialized Agencies at Geneva

GUINEA

Delegates

Professor M. K. BAH, Director-General of Health (Chief Delegate)

Mr A. SOMPARE, Ambassador of Guinea in Switzerland

Dr H. SYLLA, Director-General of Health, Ministry of Health

Alternates

Dr M. SYLLA, Deputy Chief Physician, Donka Hospital

Dr M. MARA, Chief Physician, Téliméle Region

GUINEA-BISSAU

Delegates

Mrs C. PEREIRA, Minister of Health and Social Affairs (Chief Delegate)

Dr S. J. DIAS, Director-General of Hospital Care, Ministry of Health and Social Affairs

Dr P. C. DE MEDINA, Director, Simao Mendes National Hospital

GUYANA

Delegates

Dr R. VAN WEST CHARLES, Minister of Health (Chief Delegate)

Mr C. PHILADELPHIA, Permanent Secretary, Ministry of Health

Dr Enid DENBOW, Acting Chief Medical Officer, Ministry of Health

HAITI

Delegates

Dr G. DESIR, Secretary of State for Public Health and Population (Chief Delegate)

Dr G. DESLOUCHES, Director-General, Department of Public Health

HONDURAS

Delegates

Dr J. ANDONIE FERNÁNDEZ, Minister of Public Health (Chief Delegate)

Dr J. de D. PAREDES PAZ, Assistant Director-General of Health, Ministry of Public Health (Deputy 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

HUNGARY

Delegates

Dr E. SCHULTHEISZ, Minister of Health (Chief Delegate)

Dr L. MEDVE, Secretary of State, Ministry of Health (Deputy Chief Delegate)

Dr L. SANDOR, Chief, Department of International Relations, Ministry of Health

Alternates

Mr I. SOOS, Deputy Chief, Department of International Relations, Ministry of Health

Mrs E. OLASZ, First Secretary, Ministry of Foreign Affairs

Dr J. BALOG, Director, Centre for Health Organization, Planning and Information, Ministry of Health

Advisers

Mr I. KIS, First Secretary, Permanent Mission of the Hungarian People's Republic to the United Nations Office and the Other International Organizations at Geneva

Dr L. ELIAS, Ministerial Counsellor, Ministry of Health

Mr G. MENCZER, Head of Section, Centre for Health Organization, Planning and Information, Ministry of Health

ICELAND

Delegates

Dr P. SIGURDSSON, Secretary General, Ministry of Health and Social Security (Chief Delegate)

Dr O. OLAFSSON, Chief Medical Officer, Ministry of Health and Social Security (Deputy Chief Delegate)

Mrs I. R. MAGNUSDOTTIR, Chief of Division, Ministry of Health and Social Security

Alternate

Dr G. MAGNUSSON, Deputy Chief Medical Officer, Ministry of Health and Social Security

Advisers

Dr H. JONSSON, Ambassador, Permanent Representative of Iceland to the United Nations Office and the Other International Organizations at Geneva

Mr T. KARLSSON, Counsellor, Deputy Permanent Representative of Iceland to the United Nations Office and the Other International Organizations at Geneva

INDIA

Delegates

Mr B. SHANKARANAND, Minister for Health and Family Welfare (Chief Delegate)

Dr I. D. BAJAJ, Director-General of Health Services (Deputy Chief Delegate)[1]

Mr A. P. VENKATESWARAN, Ambassador, Permanent Representative of India to the United Nations Office and the Other International Organizations at Geneva

Alternate

Mr N. N. VOHRA, Joint Secretary, Ministry of Health and Family Welfare[2]

Advisers

Mr A. S. DAS, First Secretary, Permanent Mission of India to the United Nations Office and the Other International Organizations at Geneva

Dr B. C. GHOSAL, Assistant Director-General of Health Services, Ministry of Health and Family Welfare

Mr N. S. BAKSHI, Special Assistant to the Minister of Health and Family Welfare

INDONESIA

Delegates

Mr 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)

Dr HAPSARA, Head, Planning Bureau, Secretariat General, Ministry of Health

Alternate

Mr H. M. I. SETIABUDI, Secretariat General, Ministry of Health

---

[1] Chief Delegate from 13 May.

[2] Delegate from 13 May.

Advisers

Mr M. SIDIK, Minister Counsellor, Permanent Mission of the Republic of Indonesia to the United Nations Office and the Other International Organizations at Geneva

Mr H. REKSODIPUTRO, Third Secretary, Permanent Mission of the Republic of Indonesia to the United Nations Office and the Other International Organizations at Geneva

IRAN

Delegates

Dr H. MANAFI, Minister of Health (Chief Delegate)

Mr M. A. ABBASSI TEHRANI, Director-General, Department of International Relations, Ministry of Health (Deputy Chief Delegate)

Dr B. SADRIZADEH, Director, Communicable Diseases Department, Ministry of Health

Advisers

Dr A. RAVANI, Director, Pasteur Institute

Mr D. AMERI, First Secretary, Permanent Mission of the Islamic Republic of Iran 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 SHABANDER, President, State Establishment for Health Education and Training

Dr A. HASSOUN, Director of International Health Affairs, Ministry of Health

Advisers

Dr S. Y. MICHAEL, President, State Establishment for Drug Industry and Medical Supplies

Dr S. MORKAS, Deputy Director-General of Preventive Medicine, Ministry of Health

Dr J. MUTLAK, Consultant, Ministry of Health

Mr M. A. AL-MUTLAK, Ambassador, Permanent Representative of the Republic of Iraq to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Dr S. FAHD, Permanent Mission of the Republic of Iraq to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Dr Y. KHAIRALLA, Permanent Mission of the Republic of Iraq to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Mr A. MOHAMED, Permanent Mission of the Republic of Iraq to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

IRELAND

Delegates

Dr J. H. WALSH, Deputy Chief Medical Officer, Department of Health (Chief Delegate)

Mr J. O'SULLIVAN, Assistant Secretary, Department of Health

Mr S. GAYNOR, Ambassador, Permanent Representative of Ireland to the United Nations Office and to the Specialized Agencies at Geneva

Alternate

Mr P. McDONAGH, First Secretary, Permanent Mission of Ireland to the United Nations Office and to the Specialized Agencies at Geneva

ISRAEL

Delegates

Mr E. SHOSTAK, Minister of Health (Chief Delegate)

Professor B. MODAN, Director-General, Ministry of Health (Deputy Chief Delegate)[1]

Dr J. BARROMI, Ambassador, Permanent Representative of Israel to the United Nations Office and the Specialized Agencies at Geneva[2]

Alternates

Professor B. LUNENFELD, Chief, Foreign Relations, Ministry of Health

[1] Chief Delegate from 7 May.

[2] Deputy Chief Delegate from 7 May.

Dr O. SOFFER, Ambassador, Director, Division for International Organizations, Ministry of Foreign Affairs
Professor H. DORON, Chairman, Sick Fund of the General Federation of Labour (Histadrut)
Dr Y. WAYSBORT, Deputy Director-General, Ministry of Health
Dr I. ELIASHIV, Deputy Permanent Representative of Israel to the United Nations Office and the Specialized Agencies at Geneva
Professor H. NEUFELD, Director, Heart Institute, Chaim Sheba Medical Centre, Tel Hashomer Hospital, Tel Aviv
Professor M. SHANI, Director, Chaim Sheba Medical Centre, Tel Hashomer Hospital, Tel Aviv
Dr M. MASHIACH, Head, Hospitalization Services, Ministry of Health

Advisers
Mr U. MANOR, First Secretary, Permanent Mission of Israel to the United Nations Office and the Specialized Agencies at Geneva
Ms J. DANZIGER, Chief Assistant to the Director-General, Ministry of Health

ITALY

Delegates
Mr B. ORSINI, Under-Secretary of State, Ministry of Health (Chief Delegate)
Professor R. VANNUGLI, Director, Office of International Relations, Ministry of Health (Deputy Chief Delegate)
Professor L. GIANNICO, Director-General of Public Health, Ministry of Health

Alternates
Professor F. POCCHIARI, Director Istituto Superiore di Sanità
Professor D. POGGIOLINI, Director-General of the Pharmaceutical Service, Ministry of Health
Mr M. INCISA DI CAMERANA, First Counsellor, Permanent Mission of Italy to the United Nations Office and the Other International Organizations at Geneva
Professor G. CANAPERIA, President, Italian World Health Centre
Dr Adriana VOLPINI, Ministry of Health
Professor B. PACCAGNELLA, Director, Institute of Hygiene, University of Padua
Dr F. L. ODDO, Medical Inspector General, Ministry of Health
Mr C. M. OLIVA, First Secretary, Permanent Mission of Italy to the United Nations Office and the Other International Organizations at Geneva
Mr A. IZZO, Treasury Official
Mr E. ROCCO, Office of International Relations, Ministry of Health
Professor G. LOIACONO, Ministry of Foreign Affairs

IVORY COAST

Delegates
Mr L. COULIBALY, Minister of 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
Dr I. KONE, Director of International and Regional Relations, Ministry of Public Health and Population

Alternate
Mr G. DOH, First Counsellor, Permanent Mission of the Republic of the Ivory Coast to the United Nations Office and the Specialized Agencies at Geneva and Vienna

Adviser
Mr K. F. EKRA, Counsellor, Permanent Mission of the Republic of the Ivory Coast to the United Nations Office and the Specialized Agencies at Geneva and Vienna

JAMAICA

Delegates
Dr K. BAUGH, Minister of Health (Chief Delegate)
Mr D. E. MILLER, Permanent Secretary, Ministry of Health
Dr Adeline Wynante PATTERSON, Chief Medical Officer, Ministry of Health

Alternates
Dr Deanna ASHLEY, Senior Medical Officer (Maternal and Child Health) Ministry of Health
Miss V. E. BETTON, Second Secretary, Permanent Mission of Jamaica to the United Nations Office and to the Specialized Agencies at Geneva

JAPAN

Delegates

Mr F. SUZUKI, Ambassador, Permanent Representative of Japan to the United Nations Office and the Other International Organizations at Geneva (Chief Delegate)

Dr S. YOSHIZAKI, Director-General, Statistics and Information Department, Minister's Secretariat, Ministry of Health and Welfare

Mr T. FURUSE, First Secretary, Embassy of Japan in the Federal Republic of Germany

Alternates

Mr M. NAKAMURA, Deputy Director, Specialized Agencies Division, United Nations Bureau, Ministry of Foreign Affairs

Dr Junko IKENOUCHI, Deputy Director, International Affairs Division, Minister's Secretariat, Ministry of Health and Welfare

Advisers

Dr Nobuyo HATA, Deputy Director, Division of Health Statistics, Statistics and Information Department, Minister's Secretariat, Ministry of Health and Welfare

Mr H. ISHIMOTO, First Secretary, Permanent Mission of Japan to the United Nations Office and the Other International Organizations at Geneva

Mr K. SHIMIZU, First Secretary, Permanent Mission of Japan to the United Nations Office and the Other International Organizations at Geneva

JORDAN

Delegates

Dr Z. MALHAS, Minister of Health (Chief Delegate)

Dr A. YAGHLIAN, Director of Supplies and Stores, Ministry of Health (Deputy Chief Delegate)

Dr T. LUBANI, Director, Health Planning Division, Ministry of Health[1]

Alternate

Dr H. OWEIS, Director, Health Insurance Department, Ministry of Health[2]

[1] Deputy Chief Delegate from 12 May.

[2] Delegate from 12 May.

KENYA

Delegates

Mr J. NJIRU, Assistant Minister of Health (Chief Delegate)

Mr N. NGANGA, Permanent Secretary, Ministry of Health

Dr W. KOINANGE, Director of Medical Services, Ministry of Health

Alternates

Dr F. M. MUEKE, Deputy Director of Medical Services, Ministry of Health

Dr J. A. ALUOCH, Deputy Director of Medical Services, Ministry of Health

Adviser

Mrs E. N. NGUGI, Deputy Chief Nursing Officer, Ministry of Health

KUWAIT

Delegates

Dr A. R. AL-AWADI, Minister of Public Health (Chief Delegate)

Dr A. AL-SAIF, Head, Division of International Relations, and Deputy Head, Division of Preventive Medicine, Ministry of Public Health

Mr M. F. TAWFIQ, Legal Adviser, Ministry of Public Health

Alternates

Mr A. K. JAAFAR, Director, Department of Organization and Control, Ministry of Public Health

Mr A. H. AL-AWADHI, Counsellor, Permanent Mission of Kuwait to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Mr A. AL-MOUSSA, First Secretary, Permanent Mission of Kuwait to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

LAO PEOPLE'S DEMOCRATIC REPUBLIC

Delegates

Dr K. PHOLSENA, Secretary of State for Public Health (Chief Delegate)

Dr K. SOUVANNAVONG, Chief, Department of Finance and Planning, Ministry of Public Health

LEBANON

Delegates

Mr I. KHARMA, Ambassador, Permanent Representative of the Republic of Lebanon to the United Nations Office at Geneva and the Specialized Agencies in Switzerland (Chief Delegate)

Mr T. BADAWI, Counsellor, Deputy Permanent Representative of the Republic of Lebanon to the United Nations Office at Geneva and the Specialized Agencies in Switzerland (Deputy Chief Delegate)

Miss A. I. SULTAN, Counsellor, Permanent Mission of the Republic of Lebanon to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Alternate

Mrs I. IBRAHIM PASHA, Permanent Mission of the Republic of Lebanon to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

LESOTHO

Delegates

Mr P. LEHLOENYA, Minister of Health and Social Welfare (Chief Delegate)

Mr M. T. THABANE, Permanent Secretary for Health and Social Welfare (Deputy Chief Delegate)

Dr A. P. MARUPING, Acting Director of Health Services, Ministry of Health and Social Welfare

Alternate

Dr L. M. MOHAPELOA, Senior Deputy Director, Mental Health Services, Ministry of Health and Social Welfare

LIBERIA

Delegates

Dr M. S. KARPEH, Deputy Minister of Health and Social Welfare and Chief Medical Officer (Chief Delegate)

Dr W. T. GWENIGALE, Medical Director, Bong County

Miss F. D. GIDDINGS, Deputy Chief Nursing Officer, Ministry of Health and Social Welfare

Alternates

Mr P. K. BEMAH, Counsellor (Financial Affairs), Permanent Mission of the Republic of Liberia to the United Nations Office at Geneva

Mrs E. BOWEN-CARR, Second Secretary, Permanent Mission of the Republic of Liberia to the United Nations Office at Geneva

Adviser

Dr J. N. TOGBA, Dean, School of Public Health, University of Liberia

LIBYAN ARAB JAMAHIRIYA

Delegates

Dr M. A. LENGHI, Secretary, General People's Committee for Health (Chief Delegate)

Dr A. M. ABDULHADI, Under-Secretary of Health (Deputy Chief Delegate)

Dr A. ELMESHERGHI, Director-General for Community Health, Secretariat of Health

Alternates

Dr S. HOUDARIE, Secretary of the People's Committee of the Faculty of Medicine, Al-Fateh University

Dr A. ABUDAJAJA, Professor of Community Health, Faculty of Medicine, Gar Younis University

Dr M. BEN-AMER, Secretary of the People's Committee of the Faculty of Medicine, Gar Younis University

Advisers

Dr S. AZZUZ, Attaché, Permanent Mission of the Socialist People's Libyan Arab Jamahiriya to the United Nations Office at Geneva and the Specialized Agencies at Geneva

Dr M. S. BEN HAMZA, Secretary, Department of Ophthalmology, Faculty of Medicine, Al-Fateh University

LUXEMBOURG

Delegates

Mr E. KRIEPS, Minister of Health (Chief Delegate)

Dr E. J. P. DUHR, Director of Health (Deputy Chief Delegate)[1]

[1] Chief Delegate from 7 May.

Mr J. RETTEL, Ambassador, Permanent Representative of the Grand Duchy of Luxembourg to the United Nations Office at Geneva

Alternates

Dr J. KOHL, Divisional Chief Physician, Directorate of Health, Ministry of Health

Mrs M. SCHOLTES-LENNERS, Government Adviser, Ministry of Health

Mr J.-L. WOLZFELD, First Secretary, Deputy Permanent Representative of the Grand Duchy of Luxembourg to the United Nations Office at Geneva

Mr C. A. HEMMER, Government Attaché, Ministry of Health

MADAGASCAR

Delegates

Professor E. ANDRIAMAMPIHANTONA, Secretary General, Ministry of Health (Chief Delegate)

Mr D. RAZAFIMANDIMBY, Technical Adviser, Ministry of Health

Mr P. A. TSILANIZARA, Technical Adviser, Ministry of Health

MALAWI

Delegates

Mr J. T. SANGALA, Minister of Health (Chief Delegate)

Mr W. C. SALIMA, Principal Secretary, Ministry of Health (Deputy Chief Delegate)

Dr M. C. CHIRAMBO, Chief Medical Officer, Ministry of Health

Alternates

Dr A. C. MKANDAWIRE, Senior Medical Superintendent, Ministry of Health

Dr J. KALILANI-ALFAZEMA, District Medical Officer, Ministry of Health

MALAYSIA

Delegates

Mr CHONG Hon Nyan, Minister of Health (Chief Delegate)

Dr GURMUKH SINGH, Director of Medical Services, Ministry of Health (Deputy Chief Delegate)

Mr J. A. KAMIL, Ambassador, Permanent Representative of Malaysia to the United Nations Office and the Other International Organizations at Geneva

Alternates

Dr A. RAHMAN, Director, Public Health Institute, Ministry of Health

Dr A. NGAH, Deputy Director, Division of Training and Manpower, Ministry of Health

Mr J. MOHAMMAD AMIR, Deputy Permanent Representative of Malaysia to the United Nations Office and the Other International Organizations at Geneva

Mr A. MOHD NAZIR, First 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 M. M. HUSSAIN, Minister of Health (Chief Delegate)

Dr A. S. ABDULLAH, Director of Health Services, Ministry of Health

MALI

Delegates

Dr N. TRAORE, Minister of Public Health and Social Affairs (Chief Delegate)

Dr A. DIALLO, Director General of Public Health, Ministry of Public Health and Social Affairs

Dr S. KONARÉ, Director, Division of Epidemiology and Preventive Services, Ministry of Public Health and Social Affairs

Alternates

Mr O. TALL, Technical Adviser, Ministry of Agriculture

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 Medical Officer, Department of Health (Deputy Chief Delegate)[1]
Mr A. DE BONO, Private Secretary to the Minister of Health and Environment

Alternate
Mr S. F. BORG, Second Secretary, Acting Permanent Delegate of Malta to the United Nations Office and the Specialized Agencies at Geneva

MAURITANIA

Delegates
Dr M. S. ZEIN, Director of Health (Chief Delegate)
Dr A. H. DIA, Chief, Psychiatric Service, Nouakchott Hospital

MAURITIUS

Delegates
Dr B. GHURBURRUN, Minister of Health (Chief Delegate)
Mr L. SEEWOONARAIN, Permanent Secretary, Minister of Health (Deputy Chief Delegate)
Dr D. FAREED, National WHO Programme Coordinator

MEXICO

Delegates
Dr M. CALLES, Secretary for Health and Welfare (Chief Delegate)
Dr R. ÁLVAREZ GUTIÉRREZ, Director-General of International Affairs, Secretariat for Health and Welfare (Deputy Chief Delegate)
Dr F. LEIVA MEDINA, Deputy to the Congress of the Union

Alternates
Dr R. CASTAÑEDA GUTIÉRREZ, Deputy to the Congress of the Union
Dr M. GARCÍA-VIVEROS, Director-General of Education for Health, Secretariat for Health and Welfare
Miss O. GARRIDO-RUÍZ, Third Secretary, Permanent Mission of Mexico to the United Nations Office at Geneva and the Other International Organizations in Switzerland
Dr R. MORELOS VALDES, Federal Deputy, Commission for Health
Dr J. M. LÓPEZ SANABRIA, Federal Deputy, Chief, Dermatology and Allergic Diseases Service, University of Guanajuato
Mr L. CÁRDENAS MURILLO, Congressional Representative
Dr A. GÓMEZ, Congressional Representative

MONACO

Delegates
Dr E. BOÉRI, Technical Adviser, Permanent Delegate of the Principality of Monaco to the International Health Organizations (Chief Delegate)
Mr D. L. GASTAUD, Director, Health and Social Affairs

MONGOLIA

Delegates
Dr D. NYAM-OSOR, Minister of Public Health (Chief Delegate)
Dr C. RINCHINDORJ, Head, Foreign Relations Department, Ministry of Public Health
Mr R. ARSLAN, Foreign Relations Department, Ministry of Public Health

MOROCCO

Delegates
Professor R. RAHHALI, 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
Professor A. JOUHARI-OUARAÏNI, 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 N. FIKRI BENBRAHIM, Chief, Division of Epidemiology, Ministry of Public Health
Dr A. MECHBAL, Chief, Infrastructure Division, Ministry of Public Health

[1] Chief Delegate from 8 May.

Mr A. BOJJI, First Secretary, Permanent Mission of the Kingdom of Morocco to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Mr M. HALFAQUI, Second Secretary, Permanent Mission of the Kingdom of Morocco to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Mr A. BOUZOUBAA, Ministry of Public Health

MOZAMBIQUE

Delegates
Dr P. M. MOCUMBI, Minister of Health (Chief Delegate)
Dr A. J. RODRIGUES CABRAL, Director of Preventive Medicine, Ministry of Health (Deputy Chief Delegate)
Dr Maria Beatriz FERREIRA, Coordinator, Secretariat for International Cooperation, Ministry of Health

Alternates
Dr A. A. ZILHAO, Provincial Director of Health, Ministry of Health
Mr J. ASSALE, District Director of Health, Ministry of Health
Mr O. JESSINAO, Secretary for Public Relations, Ministry of Health

NEPAL

Delegates
Dr L. POUDAYL, Acting Secretary of Health Services, Ministry of Health (Chief Delegate)
Mr V. POUDYAL, Personal Secretary to the Minister of Health

NETHERLANDS

Delegates
Mrs E. VEDER-SMIT, State Secretary for Health and Environmental Protection (Chief Delegate)
Mr G. T. HERNANDEZ, Minister of Health and Environmental Protection of the Netherlands Antilles
Dr J. VAN LONDEN, Director-General of Public Health, Ministry of Health and Environmental Protection[1]

[1] Chief Delegate from 9 to 17 May.

Alternates
Dr A. SIKKEL, Adviser to the Director-General of Public Health, Ministry of Health and Environmental Protection
Dr A. S. MULLER, Director, Department of Tropical Hygiene, Royal Tropical Institute
Mr R. R. SMIT, Counsellor, Permanent Mission of the Kingdom of the Netherlands to the United Nations Office and the Other International Organizations at Geneva
Mr I. M. DE JONG, First Secretary, Permanent Mission of the Kingdom of the Netherlands to the United Nations Office and the Other International Organizations at Geneva
Mr K. VAN KESTEREN, Head of section, Department for International Organizations, Ministry of Foreign Affairs
Mr H. MENALDA VAN SCHOUWENBURG, Division of International Affairs, Ministry of Health and Environmental Protection

Advisers
Mr R. H. FEIN, Ambassador, Permanent Representative of the Kingdom of the Netherlands to the United Nations Office and the Other International Organizations at Geneva
Dr H. H. COHEN, Director-General, National Institute of Public Health
Dr R. J. H. KRUISINGA, Adviser to the Minister of Health and Environmental Protection and to the Minister of Foreign Affairs
Mr G. LOGGERS, Deputy Chief, Inspector of Public Health, Ministry of Health and Environmental Protection
Dr J. SPAANDER, Former Director-General of the National Institute of Public Health

NEW ZEALAND

Delegates
Dr H. J. H. HIDDLESTONE, Director-General of Health, Department of Health (Chief Delegate)
Dr J. C. J. STOKE, Deputy Director, Division of Public Health, Department of Health
Mr T. C. O'BRIEN, Ambassador, Permanent Representative of New Zealand to the United Nations Office at Geneva

Alternate

Mr D. I. WHITE, Second Secretary, Permanent Mission of New Zealand to the United Nations Office at Geneva

NICARAGUA

Delegates

Mrs L. GUIDO, Minister of Health (Chief Delegate)

Dr I. TERCERO, Vice-Minister of Health

Mr J. PASQUIER, Ambassador, Permanent Representative of Nicaragua to the United Nations Office and the Other International Organizations at Geneva

Alternates

Mr J. ALANÍZ, Counsellor, Deputy Permanent Representative of Nicaragua to the United Nations Office and the Other International Organizations at Geneva

Dr G.-A. VARGAS, Deputy Permanent Representative of Nicaragua to the United Nations Office and the Other International Organizations at Geneva

Dr P. CASTELLON, Director of International Relations, Ministry of Health

NIGER

Delegates

Mr S. M. AMADOU, Minister of Public Health and Social Affairs (Chief Delegate)

Dr L. LOCO, Secretary-General, Ministry of Public Health and Social Affairs (Deputy Chief Delegate)

Dr A. I. CISSÉ, Director of Hygiene and Mobile Health Care, Ministry of Public Health and Social Affairs

Alternates

Mrs R. HOUSSEINI, Deputy Director of Social Affairs and Maternal and Child Health, Ministry of Public Health and Social Affairs

Dr B. YANSAMBOU, Director of Health of Dosso

NIGERIA

Delegates

Mr D. C. UGWU, Federal Minister of Health (Chief Delegate)

Mr O. ADENIJI, Ambassador, Permanent Representative of the Federal Republic of Nigeria to the United Nations Office and the Other International Organizations at Geneva (Deputy Chief Delegate)

Mrs F. Y. EMMANUEL, Permanent Secretary, Federal Ministry of Health

Alternates

Professor U. SHEHU, National WHO Programme Coordinator

Dr I. O. N. NSOLO, Director of Medical Services and Training, Federal Ministry of Health

Dr G. WILLIAMS, Acting Director, Public Health Services, Federal Ministry of Health

Dr A. D. KOLAWOLE, Chief Coordinator, Basic Health Service Scheme, Federal Ministry of Health

Mr G. O. BAPTIST, Assistant Director (Food), Federal Ministry of Health

Mr S. A. ILO, Deputy Secretary, Federal Ministry of Health

Professor OMOLOLU, Nutritionist, University of Ibadan

Professor A. ADENIYI, Chief Medical Director, Ilorin University Teaching Hospital

Mr F. OGBEKILE, Personal Assistant to the Federal Minister of Health

Mr A. N. CHIBUTUTU, Assistant Director, Federal Ministry of Social Development, Youth, Sports and Culture

Mr A. NRHIBUTUTU, Federal Ministry of Social Development, Youth, Sports and Culture

Mr M. B. BRIMAH, Minister, Deputy Permanent Representative of the Federal Republic of Nigeria to the United Nations Office and the Other International Organizations at Geneva

Mr J. O. COKER, Counsellor, Permanent Mission of the Federal Republic of Nigeria to the United Nations Office and the Other International Organizations at Geneva

Professor T. F. SOLANKE, Department of Surgery, University of Ibadan

Professor P. O. FASAN, Secretary, West African Postgraduate Medical College

Professor E. O. OGUNLANA, President, West African Pharmaceutical Federation

NORWAY

Delegates

Mr A. NILSEN, Minister of Health and Social Affairs (Chief Delegate)

Mr F. MELLBYE, Commissioner of Health (Deputy Chief Delegate)[1]
Dr O. T. CHRISTIANSEN, Deputy Director, Division of Hygiene and Epidemiology, Health Services of Norway[2]

Alternates
Dr E. FJAERTOFT, Chief Medical Officer, Steinkjer
Dr Ingrid LYCKE ELLINGSEN, Director, Mental Health Services
Dr A. HAUGSBØ, Chief Medical Officer, Troms

Advisers
Dr C. LERCHE, Director, National Institute for Public Health
Mr R. DAHL, Head, Health Division, Norwegian Agency for International Development
Mr I. STÅLESEN, Personal Secretary to the Minister of Health and Social Affairs
Mrs E. HELSING, Counsellor, Directorate of Health
Mr B. UTHEIM, Counsellor, Permanent Mission of Norway to the United Nations Office and the Other International Organizations at Geneva
Mrs I. MAGISTAD, Attaché, Permanent Mission of Norway to the United Nations Office and the Other International Organizations at Geneva

OMAN

Delegates
Dr M. S. AL-KHADURI, Minister of Health (Chief Delegate)
Dr A. A. K. AL-GHASSANY, Director, Department of Preventive Medicine, Ministry of Health[3]
Dr A. R. FERGANI, Adviser on Health Affairs, Ministry of Health

Alternate
Mr M. HAMDAN, Second Secretary, Permanent Mission of the Sultanate of Oman to the United Nations Office at Geneva

[1] Chief Delegate from 8 May.

[2] Deputy Chief Delegate from 8 May.

[3] Chief Delegate from 11 May.

PAKISTAN

Delegates
Dr N. JOGEZAI, Minister for Health and Social Welfare (Chief Delegate)
Mr B. JAZBI, Health Adviser to the President (Deputy Chief Delegate)
Mr S. B. AWAN, Secretary, Ministry of Health and Social Welfare

Alternates
Dr S. HASSAN, Deputy Director General Health, Ministry of Health and Social Welfare
Mr T. ALTAF, First Secretary, Permanent Mission of the Islamic Republic of Pakistan to the United Nations Office and the Specialized Agencies at Geneva
Mr M. AKRAM, Counsellor, Permanent Mission of the Islamic Republic of Pakistan to the United Nations Office and the Specialized Agencies at Geneva
Mr S. BASHIR, Second Secretary, Permanent Mission of the Islamic Republic of Pakistan to the United Nations Office and the Specialized Agencies at Geneva

PANAMA

Delegates
Dr J. MEDRANO, Minister of Health (Chief Delegate)
Dr Edith JIMÉNEZ DE BETHANCOURT, Vice-Minister of Health[4]
Mr O. FERRER, Ambassador, Permanent Representative of Panama to the United Nations Office at Geneva

Alternates
Dr M. ESCALA, Director of Family Health, Ministry of Health
Dr A. GREEN, Scientific Counsellor, Permanent Mission of Panama to the United Nations Office at Geneva
Dr R. GRAJALES ROBLES, Scientific Counsellor, Permanent Mission of Panama to the United Nations Office at Geneva

PAPUA NEW GUINEA

Delegates
Dr A. TARUTIA, Secretary for Health, Department of Health (Chief Delegate)

[4] Chief Delegate from 11 May.

Mr D. MILENG, Assistant Secretary (Finance and Management), Department of Health

PARAGUAY

Delegates

Dr A. GODOY JIMÉNEZ, Minister of Public Health and Social Welfare (Chief Delegate)

Dr J. E. ALDERETE ARIAS, Director-General of the Ministry of Public Health and Social Welfare

Dr F. ALFONSO LISBOA, Ministry of Public Health and Social Welfare

PERU

Delegates

Dr U. GARCÍA CÁCERES, Minister of Health (Chief Delegate)

Mr F. VALDIVIESO, Ambassador, Permanent Representative of Peru to the United Nations Office and the Other International Organizations at Geneva (Deputy Chief Delegate)

Dr J. PONCE DE LEÓN, Director General of International Relations, Ministry of Health[1]

Alternates

Dr J. M. SOTELO, Director General of Health Programmes, Ministry of Health

Mr J. BENAVIDES, First Secretary, Permanent Mission of Peru to the United Nations Office and the Other International Organizations at Geneva

Miss N. PANTOJA, Third Secretary, Permanent Mission of Peru to the United Nations Office and the Other International Organizations at Geneva

PHILIPPINES

Delegates

Dr A. N. ACOSTA, Assistant Secretary for Health, Ministry of Health (Chief Delegate)

Miss J. L. PALARCA, Ambassador, Deputy Permanent Representative of the Philippines to the United Nations Office and the Other International Organizations at Geneva

Dr M. ROXAS, Regional Health Director, Ministry of Health

Adviser

Mr C. V. ESPEJO, Attaché, Permanent Mission of the Philippines to the United Nations Office and the Other International Organizations at Geneva

POLAND

Delegates

Dr T. SZELACHOWSKI, Minister of Health and Social Welfare (Chief Delegate)

Dr J. ROGOWSKI, Deputy Director, Warsaw Tuberculosis Institute (Deputy Chief Delegate)[2]

Professor J. SZCZERBAN, Rector, Warsaw Academy of Medicine

Alternates

Professor H. RAFALSKI, Vice-Rector, Lodz Academy of Medicine

Dr L. S. WROBLEWSKI, Chief Physician, Voivodship of Koszalin

Dr M. MISKIEWICZ, Deputy Director, Warsaw Cardiology Institute

Mr B. MUSIELAK, Adviser to the Minister of Foreign Affairs

Adviser

Mrs I. GLOWACKA, Chief of section, Department of International Relations, Ministry of Health and Social Welfare

PORTUGAL

Delegates

Mr A. DE CARVALHO, Ambassador, Permanent Representative of Portugal to the United Nations Office and the Other International Organizations at Geneva (Chief Delegate)

Dr A. M. COELHO, Assistant Director, National Institute of Health

Dr M. COSTA SILVEIRA, Deputy Director General of Health

Alternates

Dr J. da P. BRANDAO SANTOS, Director, Health Services of Macao

Dr A. BARREIROS E SANTOS, Secretariat of State for Emigration and Portuguese Communities

[1] Deputy Chief Delegate from 11 May.

[2] Chief Delegate from 10 May.

Professor Laura G. AYRES, Research Scientist, National Institute of Health
Mr A. PINTO DE LEMOS, Attaché, Permanent Mission of Portugal to the United Nations Office and the Other International Organizations at Geneva

QATAR

Delegates
Mr K. AL MANA, Minister of Public Health (Chief Delegate)
Dr M. A. AL HARAMI, Head, General Surgery Section, Ministry of Public Health
Mr M. ABU-ALFAIN, Director, Office of the Minister of Public Health

Alternates
Dr S. TAJELDIN, Director of Preventive Medicine and International Relations Office, Ministry of Public Health
Dr Y. ABU-ALFAIN, Senior Medical Officer, Ministry of Public Health
Mr A. AL-JANAHI, Administrative Officer, Department of Primary Health Care, Ministry of Public Health
Mr M. H. AL JABER, First Secretary, Permanent Mission of the State of Qatar to the United Nations and Other International Organizations in Geneva

REPUBLIC OF KOREA

Delegates
Mr Myung-Kee CHUN, Minister of Health and Social Affairs (Chief Delegate)
Mr Sang Yong PARK, Ambassador, Permanent Observer of the Republic of Korea to the United Nations Office and Permanent Delegate to the Other International Organizations at Geneva (Deputy Chief Delegate)
Dr Kyong-Shik CHANG, Director-General, Bureau of Medical Affairs, Ministry of Health and Social Affairs

Alternates
Mr Sang-Ha HAN, Director, International Affairs Division, Ministry of Health and Social Affairs
Mr Hee-Hwan KIM, Secretary to the Minister of Health and Social Affairs
Mr Yung Kook KWON, Third Secretary, Office of the Permanent Observer of the Republic of Korea to the United Nations Office and Permanent Delegation to the Other International Organizations at Geneva
Mr Jai Hyon YOO, Assistant Director, International Organizations Division I, Ministry of Foreign Affairs

ROMANIA

Delegates
Professor E. PROCA, Minister of Health (Chief Delegate)
Professor M. MALIŢA, Ambassador, Permanent Representative of the Socialist Republic of Romania to the United Nations Office and the Specialized Agencies at Geneva (Deputy Chief Delegate)
Dr A. BULLA, Research Scientist, Academy of Medical Sciences

Alternates
Dr R. OZUN, Director, Ministry of Health
Mr O. IONESCU, Counsellor, Permanent Mission of the Socialist Republic of Romania to the United Nations Office and the Specialized Agencies at Geneva
Dr C.-A. HAVRILIUC, Vice-Director, Ministry of Health
Mr M. BICHIR, Second Secretary, Permanent Mission of the Socialist Republic of Romania to the United Nations Office and the Specialized Agencies at Geneva
Mr M. ALDEA, Second Secretary, Ministry of Foreign Affairs

RWANDA

Delegates
Dr I. MUSAFILI, Minister of Public Health (Chief Delegate)
Dr J.-B. RWASINE, Director-General of Pharmacies, Ministry of Public Health (Deputy Chief Delegate)
Dr G. GATERA, Chief of Surgery Service, Butare Hospital

SAMOA

Delegates
Mr A. FAUMUINA, Minister of Health (Chief Delegate)

Dr K. W. RIDINGS, Director-General of Health (Deputy Chief Delegate)
Ms Helen BLAKELOCK, Private Secretary to the Minister of Health

SAN MARINO

Delegates

Mr D. E. THOMAS, Minister Plenipotentiary, Permanent Observer of the Republic of San Marino to the United Nations Office and Permanent Delegate to the Other International Organizations at Geneva (Chief Delegate)
Mr P. CHIARUZZI, Director-General, Social Security Institute
Dr N. SIMETOVIC, Deputy Chief, Division of General Medicine, State Hospital

SAO TOME AND PRINCIPE

Delegates

Dr C. TINY, Minister of Health and Sports (Chief Delegate)
Dr A. S. MARQUES DE LIMA, Director of Hospitals, Ministry of Health and Sports (Deputy Chief Delegate)
Dr F. SEQUEIRA, Clinical Director of the Sao Tome Central Hospital

SAUDI ARABIA

Delegates

Dr H. A. R. GEZAIRY, Minister of Health (Chief Delegate)
Dr S. S. ISLAM, Technical Adviser to the Minister of Health (Deputy Chief Delegate)
Dr M. I. AL-KHAWASHKY, Director, Riyadh Central Hospital

Alternates

Dr A. R. ALSUWILEM, Chief Paediatrician, Maternity and Children's Hospital
Mr N. H. QUTUB, Secretary for International Conference Affairs to the Minister of Health

Advisers

Dr J. M. AASHI, Secretary-General for Health
Mr A.-G. A'SHI, Secretary-General, Arab Red Crescent and Red Cross Societies

SENEGAL

Delegates

Mr M. DIOP, Minister of Public Health (Chief Delegate)
Mr A. SENE, Ambassador, Permanent Representative of the Republic of Senegal to the United Nations Office and the Specialized Agencies at Geneva
Professor P. A. R. KANE, Deputy to the National Assembly

Alternates

Dr M. TOURÉ, Director of Hygiene and Health Care, Ministry of Public Health
Professor O. SYLLA, Technical Adviser, Ministry of Public Health
Mr M. LO, Technical Adviser, Ministry of Public Health
Dr M. NDIAYE, Counsellor, Embassy of the Republic of Senegal in Switzerland

SEYCHELLES

Delegates

Mrs G. THOMAS, Principal Secretary, Department of Health (Chief Delegate)
Dr K. S. CHETTY, Principal Medical Officer, Community Health Division, Department of Health

SIERRA LEONE

Delegates

Mr F. M. MINAH, Minister of Health (Chief Delegate)
Mr F. M. B. SAWI, Permanent Secretary, Ministry of Health
Dr (Mrs) Belmont WILLIAMS, Chief Medical Officer, Ministry of Health

Alternates

Mrs H. SUMNER, Embassy of Sierra Leone in Italy
Dr J. C. O. MENDS, City Council, Freetown

SINGAPORE

Delegates

Dr Chew Chin HIN, Director, Tan Tock Seng Hospital (Chief Delegate)
Mr Chew Tai SOO, Deputy Permanent Representative of the Republic of Singapore to the United Nations Office and the Specialized Agencies at Geneva

Miss O. JOSEPH, Third Secretary, Permanent Mission of the Republic of Singapore to the United Nations Office and the Specialized Agencies at Geneva

SOMALIA

Delegates

Dr A. M. HASSAN, Acting Director-General, Ministry of Health (Chief Delegate)

Dr S. N. HUSSAIN, Head of International Health Relations, Ministry of Health

Mr A. S. OSMAN, Ambassador, Permanent Representative of the Somali Democratic Republic to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Alternate

Mrs F. ENO-HASSAN, Second Counsellor, Permanent Mission of the Somali Democratic Republic to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

SPAIN

Delegates

Mr J. SANCHO ROF, Minister of Labour, Health and Social Security (Chief Delegate)

Dr L. SÁNCHEZ-HARGUINDEY, Secretary of State for Health, Ministry of Health and Social Security

Mr E. DOMINGUEZ-PASSIER, Ambassador, Permanent Representative of Spain to the United Nations Office at Geneva and Other International Organizations in Switzerland

Alternates

Dr L. VALENCIANO, Director-General of Public Health, Ministry of Health and Social Security

Dr L. MUNUERA, Director-General of Health Planning, Ministry of Health and Social Security

Professor J. M. SEGOVIA DE ARANA, Director-General, Health Research Fund (Social Security), National Institute of Health; Professor of Internal Medicine, Independent University of Madrid

Mr J. I. NAVARRO, Deputy Permanent Representative of Spain to the United Nations Office at Geneva and Other International Organizations in Switzerland

Advisers

Mr J. DE LA CUEVA, Assistant Director-General of International Affairs, Ministry of Health and Social Security

Mr G. CLAVERO, Director, Technical Office of the Secretariat of State for Health, Ministry of Health and Social Security

Dr L. CAÑADÁ ROYO, Assistant Director-General of Health Programmes, General Directorate of Public Health, Ministry of Health and Social Security

Dr R. CONTY LARRANZ, Assistant Director-General of Food Hygiene, Ministry of Health and Social Security

Dr M. DE LA MATA, Assistant Director-General of Health Assistance and Pharmaceutical Services, National Institute of Health

Mr L. NAGORE, First Secretary, Permanent Mission of Spain to the United Nations Office at Geneva and Other International Organizations in Switzerland

SRI LANKA

Delegates

Mr G. JAYASURIYA, Minister of Health (Chief Delegate)

Mr B. C. PERERA, Secretary, Ministry of Health

Alternates

Mr D. M. JAYASEKERA, Counsellor, Acting Chargé d'Affaires, Permanent Mission of the Democratic Socialist Republic of Sri Lanka to the United Nations Office and the Other International Organizations at Geneva

Mr H. M. G. S. PALIHAKKARA, Third Secretary, Permanent Mission of the Democratic Socialist Republic of Sri Lanka to the United Nations Office and the Other International Organizations at Geneva

SUDAN

Delegates

Mr K. H. ABBAS, Minister of Health (Chief Delegate)

Dr S. M. MUSTAFA, Under-Secretary, Ministry of Health

Dr M. S. AL-SARRAG, Director-General of International Health Relations, Ministry of Health

Alternates

Mr O. Y. BIRIDO, Ambassador, Permanent Representative of the Democratic Republic of Sudan to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Dr M. Y. EL-AWAD, Director-General of Curative Medicine, Ministry of Health
Dr N. WARILLE, Director of Health (Southern Region), Ministry of Health
Dr Y. OSMAN, Director, Occupational Health Department, Ministry of Health
Mr H. OSMAN, Secretary to the Minister of Health
Mr I. A. HAMRA, Deputy Permanent Representative of the Democratic Republic of Sudan to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Mr Y. ISMAIL, Counsellor, Permanent Mission of the Democratic Republic of Sudan to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Mr M. S. E. D. ABBAS, First Secretary, Permanent Mission of the Democratic Republic of Sudan to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Mr K. E. T. IDRIS, Second Secretary, Permanent Mission of the Democratic Republic of Sudan to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

SURINAME

Delegates

Professor B. OOSTBURG, Director, Bureau of Public Health Care (Chief Delegate)
Mr H. PRADE, Ambassador of Suriname to the Netherlands
Mrs G. RIDDER-RUSTWIJK, Deputy Permanent Secretary, Directorate for Foreign Affairs

SWAZILAND

Delegates

Dr S. W. HYND, Minister of Health (Chief Delegate)
Dr Z. M. DLAMINI, Director of Medical Services, Ministry of Health
Dr B. B. GAMA, Acting Senior Medical Officer, Ministry of Health

SWEDEN

Delegates

Dr Barbro WESTERHOLM, Director-General, National Board of Health and Welfare (Chief Delegate)[1]
Dr S. ALSÉN, Assistant Director-General, National Board of Health and Welfare[2]
Mr I. NYGREN, Director, Health and Medical Care Department, Ministry of Health and Social Affairs

Alternates

Mr H. V. EWERLÖF, Ambassador, Permanent Representative of Sweden to the United Nations Office and the Other International Organizations at Geneva
Mr B. MATHSSON, Head of Section, Ministry of Health and Social Affairs
Mr E. CORNELL, Minister, Deputy Permanent Representative of Sweden to the United Nations Office and the Other International Organizations at Geneva
Miss U. FREDRIKSSON, Counsellor, Permanent Mission of Sweden to the United Nations Office and the Other International Organizations at Geneva
Mr H. O. MAGNUSSON, Head of section, United Nations Division, Ministry of Foreign Affairs

Advisers

Mr S.-E. BERGMAN, Head of department, Federation of Swedish County Councils
Dr O. PETERSSON, Director, Uppsala University Hospital
Mrs U. LAGERGREN, Permanent Mission of Sweden to the United Nations Office and the Other International Organizations at Geneva

SWITZERLAND

Delegates

Dr U. FREY, Director, Federal Office of Public Health (Chief Delegate)
Dr C. FLEURY, Chief, Communicable Diseases Section, Federal Office of Public Health (Deputy Chief Delegate)
Mr M. JEANRENAUD, Minister, Permanent Mission of Switzerland to the International Organizations at Geneva

[1] Chief Delegate from 11 to 15 May.

[2] Chief Delegate from 4 to 10 May and from 16 May.

Alternates
Dr Immita CORNAZ, Scientific Assistant, Directorate for Cooperation in Development and Humanitarian Aid, Department of Foreign Affairs
Dr H. SEILER, Scientific Assistant, Federal Office of Public Health
Mr H. KELTERBORN, Scientific Assistant, Federal Office of Public Health

Advisers
Mr F. PICTET, Ambassador, Head of the Permanent Mission of Switzerland to the International Organizations at Geneva
Mr J.-P. GONTARD, Head, Studies and Projects Service, Institute of Development Studies, Geneva University
Dr J. F. MARTIN, Deputy to the Vaud Cantonal Medical Officer

SYRIAN ARAB REPUBLIC

Delegates
Dr G. RIFAI, Minister of Health (Chief Delegate)
Mr M. BAATH, Vice-Minister of Health
Dr W. HAJ HUSSEIN, Director of International Relations, Ministry of Health

Alternate
Dr F. HLOUBI, National Hospital, Aleppo

Advisers
Mr D.-A. EL-FATTAL, Ambassador, Permanent Representative of the Syrian Arab Republic to the United Nations Office and the Specialized
Dr A. SAKER, Minister Plenipotentiary, Permanent Mission of the Syrian Arab Republic to the United Nations Office and the Specialized Agencies at Geneva
Mr M. J. AL-BAROUDI, Minister Counsellor, Permanent Mission of the Syrian Arab Republic to the United Nations Office and the Specialized Agencies at Geneva
Mr A. HANNA, Third Secretary, Permanent Mission of the Syrian Arab Republic to the United Nations Office and the Specialized Agencies at Geneva

THAILAND

Delegates
Professor P. TUCHINDA, Under-Secretary of State for Public Health, Ministry of Public Health (Chief Delegate)
Dr P. SUVANNUS, Director, Family Health Division, Health Department, Ministry of Public Health
Dr S. PLIANBANGCHANG, Secretary, National Advisory Board for Diseases Prevention and Control, Ministry of Public Health

Alternate
Mr V. BHINYOYING, Counsellor, Deputy Permanent Representative of Thailand to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Adviser
Miss V. CHANTRASMI, Second Secretary, Permanent Mission of Thailand to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

TOGO

Delegates
Mr H. BODJONA, Minister of Public Health (Chief Delegate)
Dr M. T. HOUÉNASSOU-HOUANGBÉ, Director General of Public Health, Ministry of Public Health
Dr K. P. WONEGOU, Chief Physician, Bassar Health Subdivision

TONGA

Delegate
Dr S. FOLIAKI, Director of Health, Ministry of Health

TRINIDAD AND TOBAGO

Delegates
Mr W. NAIMOOL, Ambassador, Permanent Representative of Trinidad and Tobago to the United Nations Office at Geneva and the Specialized Agencies in Europe (Chief Delegate)
Dr Elizabeth QUAMINA, Chief Medical Officer, Ministry of Health
Mr O. ALI, Counsellor, Permanent Mission of Trinidad and Tobago to the United Nations Office at Geneva and the Specialized Agencies in Europe

Alternate

Miss Y. GITTENS, First Secretary, Permanent Mission of Trinidad and Tobago to the United Nations Office at Geneva and the Specialized Agencies in Europe

TUNISIA

Delegates

Mr R. SFAR, Minister of Public Health (Chief Delegate)

Mr S. BEN AMMAR, Ambassador, Permanent Representative of Tunisia to the United Nations Office at Geneva and the Specialized Agencies in Switzerland (Deputy Chief Delegate)

Dr M. FOURATI, Director-General, Ministry of Public Health

Alternates

Mrs J. DAGHFOUS, Assistant Director of International Cooperation, Ministry of Public Health

Mr I. LEJRI, Counsellor, Permanent Mission of Tunisia to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Professor T. NACEF, Director, Pedagogical Research and Training Centre, Ministry of Public Health

Dr H. SAIED, Inspector General, Ministry of Public Health

Miss R. BEN LAHBIB, Chief of Section, Division of International Cooperation, Ministry of Public Health

Advisers

Professor H. BEN AYED, Dean, Faculty of Medicine, Tunis

Professor (Mrs) S. YACOUBI, Dean, Faculty of Medicine of Sousse

Professor N. MOURALI, Director, National Cancer Institute

Professor A. CHADLI, Director, Pasteur Institute, Tunis

Professor B. HAMZA, Director, National Institute of Child Health

Dr A. R. FARAH, Director of Preventive and Social Medicine, Ministry of Public Health

Dr H. BEN SLAMA, Secretary-General, Union of Arab Physicians

Dr R. DALI, Medical Director, National Office of Family Planning and Population, Ministry of Public Health

Professor H. M'HENNI, Physician, National Institute of Child Health

Mr H. BEN SOLTANE, Attaché de Cabinet, Ministry of Public Health

Mr Z. EL FITOURI, Attaché de Cabinet, Ministry of Public Health

Professor M. YACOUB, Dean, Faculty of Dental Surgery, Monastir

Mr K. EL HAFDHI, Deputy Permanent Representative of Tunisia to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

TURKEY

Delegates

Professor N. AYANOĞLU, Minister of Health and Social Assistance (Chief Delegate)[1]

Professor I. DOĞRAMACI, President, Council of Rectors of Turkish Universities; Member of the Supreme Health Council (Chief Delegate)[2]

Dr E. SENERDEM, Under-Secretary of State, Ministry of Health and Social Assistance (Deputy Chief Delegate)

Dr E. AKER, Director-General of Public Health, Ministry of Health and Social Assistance

Alternates

Mr B. CANKOREL, Counsellor, Permanent Mission of Turkey to the United Nations Office at Geneva and the Other International Organizations in Switzerland

Professor O. ÖZTÜRK, Chairman, Department of Psychiatry, Hacettepe University, Ankara; Director, Gölbaşi Mental Health Institute, Ankara

Advisers

Professor T. PIRNAR, Rector, Hacettepe University; Director, Institute of Environmental Health, Ankara

Professor M. ÇORUH, Director, Institute of Population Studies, Hacettepe University, Ankara

UGANDA

Delegates

Dr E. NKWASIBWE, Minister of Health (Chief Delegate)

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[1] From 13 to 16 May.

[2] From 4 to 12 May and from 17 May.

Dr J. H. GESA, Permanent Secretary, Ministry of Health (Deputy Chief Delegate)
Dr S. I. OKWARE, Assistant Director of Medical Services, Ministry of Health

Alternates
Dr J. T. KAKITAHI, Senior Lecturer, Makerere Medical School
Mr J. GAIFUBA, Ministry of Health
Mr B. B. OLUKA, Personal Assistant to the Minister of Health

UNION OF SOVIET SOCIALIST REPUBLICS

Delegates
Dr S. P. BOURENKOV, Minister of Health of the USSR (Chief Delegate)
Professor N. N. BLOKHIN, President, USSR Academy of Medical Sciences
Dr D. D. VENEDIKTOV, Deputy Minister of Health of the USSR[1]

Alternates
Mrs Z. V. MIRONOVA, Ambassador, Permanent Representative of the USSR to the United Nations Office and the Other International Organizations at Geneva
Professor Y. F. ISAKOV, Head, Central Board of Teaching Establishments, Ministry of Health of the USSR
Professor Ju. P. LISICYN, Director, All-Union Institute for Research on Medical and Medico-technical Information

Advisers
Dr E. V. GALAHOV, Head, Foreign Health Services Department, Semaško All-Union Institute for Social Hygiene and Public Health Administration
Mr D. A. SOKOLOV, Counsellor, Department of International Economic Organizations, Ministry of Foreign Affairs of the USSR
Dr S. K. LITVINOV, Deputy Chief, External Relations Board, Ministry of Health of the USSR
Mr A. A. KISELEV, Counsellor, Permanent Representation of the USSR to the United Nations Office and the Other International Organizations at Geneva
Dr A. I. SAVINYH, Senior Inspector, External Relations Board, Ministry of Health of the USSR
Mr V. V. ZAVOLSKI, Senior Inspector, External Relations Board, Ministry of Health of the USSR
Dr V. V. FEDOROV, Section Chief, Semaško All-Union Institute of Social Hygiene and Public Health Administration, Ministry of Health of the USSR
Dr E. KURICYN, Assistant to the Deputy Minister of Health of the USSR

[1] Chief Delegate from 11 May.

UNITED ARAB EMIRATES

Delegates
Mr H. AL-MADFA, Minister of Health (Chief Delegate)
Dr S. AL-QASSIMI, Under-Secretary, Ministry of Health
Dr A. R. JAFFAR, Assistant Under-Secretary, Chief of Curative Medicine, Ministry of Health

Alternates
Dr M. H. ABDULLA, Director of Dental Services, Ministry of Health
Professor M. K. YASSEEN, Legal Adviser, Permanent Mission of the United Arab Emirates to the United Nations Office and the Specialized Agencies at Geneva
Mr E. K. AL-MUHAIRI, Director of International Relations, Ministry of Health
Professor A. L. AL-BADRI, Medical Adviser, Ministry of Health

Adviser
Mr A. A. AL-BAKRI, Economic Adviser, Permanent Mission of the United Arab Emirates to the United Nations Office and the Specialized Agencies at Geneva

UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND

Delegates
Sir Henry YELLOWLEES, Chief Medical Officer, Department of Health and Social Security (Chief Delegate)
Dr E. L. HARRIS, Deputy Chief Medical Officer, Department of Health and Social Security[2]
Dr J. J. A. REID, Chief Medical Officer, Scottish Home and Health Department

[2] Chief Delegate from 11 May.

Alternates

Dr I. T. FIELD, Head, International Health Division, Department of Health and Social Security, and Chief Medical and Health Services Adviser, Overseas Development Administration

Dame Phyllis FRIEND, Chief Nursing Officer, Department of Health and Social Security

Mr I. G. GILBERT, Under-Secretary, Department of Health and Social Security

Mr J. HALLOWELL, Assistant Secretary, Department of Health and Social Security

Mr P. H. R. MARSHALL, Ambassador, Permanent Representative of the United Kingdom to the United Nations Office and the Other International Organizations at Geneva

Advisers

Dr P. A. HYZLER, Senior Medical Officer, Department of Health and Social Security

Mr J. PARKER, Principal, Department of Health and Social Security

Mr B. HARDING, Principal, Ministry of Agriculture, Fisheries and Food

Mr C. LONG, Counsellor, Deputy Permanent Representative of the United Kingdom to the United Nations Office and the Other International Organizations at Geneva

Mr C. L. MAYHEW, Second Secretary, Permanent Mission of the United Kingdom to the United Nations Office and the Other International Organizations at Geneva

Miss C. A. HART, Third Secretary, Permanent Mission of the United Kingdom to the United Nations Office and the Other International Organizations at Geneva

UNITED REPUBLIC OF CAMEROON

Delegates

Mr A. ETEME-OLOA, Minister of Public Health (Chief Delegate)

Mr M. HAMAN DICKO, Ambassador, Permanent Representative of the United Republic of Cameroon to the United Nations Office at Geneva and the Specialized Agencies in Switzerland (Deputy Chief Delegate)

Dr S. ATANGANA, Technical Adviser, Ministry of Public Health

Alternates

Professor D. OBOUNOU-AKONG, Deputy Director of Public Health, Ministry of Public Health

Mr A. EBÉDÉ, First Secretary, Embassy of the United Republic of Cameroon in Belgium

UNITED REPUBLIC OF TANZANIA

Delegates

Dr A. D. CHIDUO, Minister of Health of Tanzania Mainland (Chief Delegate)

Mr H. MAKAME, Minister of Health and Social Welfare, Zanzibar (Deputy Chief Delegate)

Dr K. N. M. MTERA, Director of Preventive Health Services, Tanzania Mainland

Alternates

Dr W. K. CHAGULA, Ambassador, Permanent Representative of the United Republic of Tanzania to the United Nations Office at Geneva

Dr M. I. HASSAN, Director of Hospital Services, Zanzibar

UNITED STATES OF AMERICA

Delegates

Dr E. N. BRANDT Jr, Assistant Secretary for Health, Department of Health and Human Services (Chief Delegate)

Dr C. E. KOOP, Deputy Assistant Secretary for Health, Department of Health and Human Services

Dr R. J. RUBIN, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services

Alternates

Mr G. B. HELMAN, Ambassador, United States Permanent Representative to the United Nations Office and the Other International Organizations at Geneva

Mr N. A. BOYER, Director for Health and Narcotics Programs, Bureau of International Organization Affairs, Department of State

Dr J. H. BRYANT, Deputy Assistant Secretary for International Health, Department of Health and Human Services

Dr S. C. JOSEPH, Acting Assistant Administrator, Bureau of Development Support, Agency for International Development

Advisers

Miss H. AUGUST, Third Secretary, United States Mission to the United Nations Office and the Other International Organizations at Geneva

Miss R. BELMONT, Director, Division for Multilateral Programs, Office of International Health, Department of Health and Human Services

Mr S. BOND, Legal Counsellor, United States Mission to the United Nations Office and the Other International Organizations at Geneva

Dr J. CHIRIBOGA, Director, Environmental and Biomedical Institute, Faculty of Medicine, University of Puerto Rico

Mr D. C. ELLER, Deputy United States Permanent Representative to the United Nations Office and the Other International Organizations at Geneva

Dr R. D. FISCHER, International Health Attaché, United States Mission to the United Nations Office and the Other International Organizations at Geneva

Dr W. FOEGE, Director, Centers for Disease Control, Department of Health and Human Services

Dr C. J.-M. LENFANT, Director, Fogarty International Center, National Institutes of Health, Department of Health and Human Services

Ms M. F. LOWE, Acting Associate Executive Secretary, Department of Health and Human Services

Mr J. W. MACDONALD Jr, Counsellor (Political Affairs), United States Mission to the United Nations Office and the Other International Organizations at Geneva

Dr D. HOPKINS, Assistant Director for International Health, Centers for Disease Control, Department of Health and Human Services

UPPER VOLTA

Delegates

Dr J.-M. KYELEM, Minister of Public Health (Chief Delegate)

Dr M. OUOBA, Director of Public Health, Ministry of Public Health

Mr R. NANEMA, Nutritionist, Ministry of Public Health

URUGUAY

Delegates

Mr L. NICOLETTI, Under-Secretary for Public Health (Chief Delegate)

Dr J. J. BACIGALUPI, Director General of Health, Ministry of Public Health

Dr A. AGUIAR, Adviser, Ministry of Public Health

Alternate

Dr A. MOERZINGER, First Secretary, Permanent Mission of the Eastern Republic or Uruguay to the United Nations Office and the Specialized Agencies at Geneva

VENEZUELA

Delegates

Dr L. J. GONZÁLEZ HERRERA, Minister of Health and Social Assistance (Chief Delegate)

Mr F. HOYOS-SOSA, Minister Counsellor, Permanent Mission of the Republic of Venezuela to the United Nations Office and the Other International Organizations at Geneva (Deputy Chief Delegate)[1]

Dr R. ALBORNOZ, Director of Public Health, Ministry of Health and Social Assistance

Alternates

Dr J. RODRÍGUEZ DÍAZ, Chief, International Public Health Office, Ministry of Health and Social Assistance

Dr Maria ANDRADE DE BARONE, Director of the General Secretariat, Ministry of Health and Social Assistance

Mr O. AGUILAR PARDO, Second Secretary, Permanent Mission of the Republic of Venezuela to the United Nations Office and the Other International Organizations at Geneva

Dr F. FIGUERA, Commissioner General of Health for the State of Monagas

Dr Josefa DE ROMAN, Pharmacist, National Institute of Hygiene

VIET NAM

Delegates

Mr VO ANH TUAN, Ambassador, Permanent Representative of the Socialist Republic of Viet Nam to the United Nations Office and the Other International Organizations at Geneva (Chief Delegate)

[1] Chief Delegate from 11 May.

Professor HOANG DINH CÂU, Vice-Minister of Health (Deputy Chief Delegate)[1]
Mr NGUYEN VAN TRONG, Director of the Department of External Relations, Ministry of Health

Alternate
Mr NGUYEN MANH DUNG, Attaché, Permanent Mission of the Socialist Republic of Viet Nam to the United Nations Office and the Other International Organizations at Geneva

YEMEN

Delegates
Dr M. AL-KABAB, Minister of Health (Chief Delegate)
Mr H. ALMAGBALY, Ambassador, Permanent Representative of the Yemen Arab Republic to the United Nations Office at Geneva and the Specialized Agencies in Europe
Mr K. AL-SAKKAF, Director, International Health Relations Department, Ministry of Health

Alternates
Dr J. SAEED, Co-director, Yemeni-Swedish Association
Dr H. AL-DEILAMI, Director of Curative Medicine, Ministry of Health

YUGOSLAVIA

Delegates
Mr S. PEPOVSKI, Member of the Federal Executive Council; President of the Federal Committee for Labour, Health and Social Welfare (Chief Delegate)
Professor D. JAKOVLJEVIĆ, Vice-President of the Executive Council of the Assembly of the Socialist Autonomous Province of Vojvodina (Deputy Chief Delegate)
Dr P. POPOVIĆ, Member of the Executive Council of the Assembly of the Socialist Republic of Croatia and President of the Republic Committee for Health and Social Welfare of the Socialist Republic of Croatia

Advisers
Dr M. VRHUNEC, Ambassador, Permanent Representative of the Socialist Federal Republic of Yugoslavia to the United Nations Office and the International Organizations at Geneva
Dr D. KOMADINA, Director, Federal Bureau for Social Welfare
Mr D. BOBAREVIĆ, Head of the Group for International Cooperation in the Field of Health and Social Welfare, Federal Committee for Labour, Health and Social Welfare
Miss Z. ILIĆ, Counsellor, Permanent Mission of the Socialist Federal Republic of Yugoslavia to the United Nations Office and the International Organizations at Geneva
Mrs S. MOMCILOVIĆ, Senior Adviser for Multilateral Cooperation, Federal Committee for Labour, Health and Social Welfare
Mr Z. JERKIĆ, Attaché, Permanent Mission of the Socialist Federal Republic of Yugoslavia to the United Nations Office and the International Organizations at Geneva

ZAIRE

Delegates
Dr FALAKI MOLOMA, Secretary of State for Public Health (Chief Delegate)
Mr A. N. BAGBENI, Ambassador, Permanent Representative of the Republic of Zaire to the United Nations Office at Geneva and the Specialized Agencies in Switzerland (Deputy Chief Delegate)
Mr F. B. KIBIKONDA, Counsellor, Department of Public Health

Alternates
Dr M. N. NKONDI, Director, Department of Public Health
Dr KABAMBA NKAMANY, Medical Director, Department of Public Health
Mrs E. ESAKI-KABEYA, First Secretary, Permanent Mission of the Republic of Zaire to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Mr N. B. MOYILA, First Secretary, Permanent Mission of the Republic of Zaire to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

[1] Chief Delegate from 15 May.

Mr G. OSIL, Second Secretary, Permanent Mission of the Republic of Zaire to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

ZAMBIA

Delegates

Mr B. C. KAKOMA, Minister of Health (Chief Delegate)
Dr J. M. KASONDE, Permanent Secretary of Health and Director of Medical Services, Ministry of Health
Dr W. C. MWAMBAZI, Assistant Director of Medical Services, Ministry of Health

ZIMBABWE

Delegates

Dr H. S. M. USHEWOKUNZE, Minister of Health (Chief Delegate)
Dr J. S. B. PREECE, Secretary for Health, Ministry of Health[1]
Dr J. C. MUVUTI, Deputy Secretary for Health (Health Planning), Ministry of Health

Alternates

Dr N. O. MUGWAGWA, Director of National Nutrition, Ministry of Health[2]
Dr Rose J. NDLOVU, Health Training Coordinator, Ministry of Health
Mrs R. M. MUSHONGA, Nursing Services Officer, Ministry of Health

Adviser

Miss E. PILLAY, Private Secretary to the Minister of Health

REPRESENTATIVE OF AN ASSOCIATE MEMBER

NAMIBIA

Dr Libertina I. AMATHILA, Deputy Secretary for Health and Social Welfare

OBSERVERS FOR A NON-MEMBER STATE

HOLY SEE

Monsignor L. BRESSAN
Dr P. BOLECH
Dr Marie-Thérèse GRABER-DUVERNAY

OBSERVERS

ORDER OF MALTA

Count J. DE NOÜE, Ambassador, Permanent Delegate of the Sovereign Order of Malta to the International Organizations at Geneva
Count E. DECAZES, Ambassador, Deputy Permanent Delegate of the Sovereign Order of Malta to the International Organizations at Geneva
Mr R. VILLARD DE THOIRE, Counsellor, Permanent Delegation of the Sovereign Order of Malta to the International Organizations at Geneva
Dr A. VOGT, Secretary-General, International Committee of the Sovereign Order of Malta for Aid to Leprosy Victims
Professor J. LANGUILLON, Technical Adviser, International Committee of the Sovereign Order of Malta for Aid to Leprosy Victims

[1] Chief Delegate from 15 May.

[2] Delegate from 15 May.

OBSERVERS INVITED IN ACCORDANCE WITH RESOLUTION WHA27.37

PALESTINE LIBERATION ORGANIZATION

Dr F. ARAFAT, President of the Palestine Red Crescent Society
Mr D. BARAKAT, Permanent Observer of the Palestine Liberation Organization to the United Nations Office at Geneva
Dr A. ABU HASSAN
Dr A. BASHIR
Mrs W. SIYAN
Mr Y. YAKOUBIAN

PAN AFRICANIST CONGRESS OF AZANIA

Mrs H. MNGAZA

MEMBERS OF THE SPECIAL COMMITTEE OF EXPERTS TO STUDY THE HEALTH CONDITIONS OF THE INHABITANTS OF THE OCCUPIED TERRITORIES IN THE MIDDLE EAST

Dr M. TOURÉ (Chairman)
Dr B. WASISTO
Dr T. IONESCU

REPRESENTATIVES OF THE UNITED NATIONS AND RELATED ORGANIZATIONS

United Nations

Mr W. H. TARZI, Director, External Relations and Inter-Agency Affairs
Mr T. S. ZOUPANOS, Deputy to the Director, External Relations and Inter-Agency Affairs
Mrs A. S. DJERMAKOYE, External Relations and Inter-Agency Affairs Officer
Dr G. LING, Director, Division of Narcotic Drugs
Mr B. WELSH, Division for Economic and Social Information
Mr P. STONE, Editor-in-Chief, "Development Forum", Division for Economic and Social Information
Mr H. NABULSI, Executive Coordinator, United Nations Volunteers Programme
Mr R. KNUTSSON, Chief, Programme Operations Section, United Nations Volunteers Programme
Mr H. ANSAR-KHAN, Liaison Officer, Centre against Apartheid
Mr B. RAMCHARAN, Special Assistant to the Director, Division of Human Rights
Mrs L. WALDHEIM-NATURAL, Chief, Geneva Unit, Centre for Disarmament
Miss M.-A. ORSINI, Centre for Disarmament
Dr V. KARNIK, Office of the Disaster Relief Coordinator

United Nations Children's Fund

Mr M. H. POLEMARCHAKIS, Director ad interim, UNICEF Office for Europe
Mr J. WILLIAMS, Coordinator for External Relations, UNICEF Office for Europe
Mrs L. MAIR, Special Adviser on Women in Development
Mr N. BOWLES, Consultant
Dr L. J. TEPLY, Senior Nutritionist
Mr D. MILLWOOD, Consultant
Mr M. ENNALS, Special Consultant
Mr R. K. MANOFF, Special Adviser to the Executive Director

United Nations Relief and Works Agency for Palestine Refugees in the Near East

Dr G. MEILLAND, Director of Health and WHO Programme Coordinator

United Nations Development Programme

Mr P. BOURGOIS, Assistant Administrator and Director, UNDP European Office
Mr N. J. DESAI, Senior External Relations Officer, UNDP European Office

United Nations Environment Programme

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Secretary: Dr O. W. CHRISTENSEN (Coordination with Other Organizations)

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