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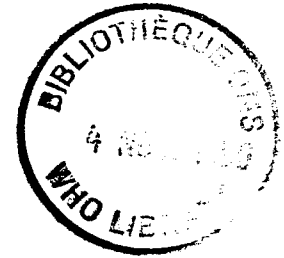
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THE MEANING OF TECHNICAL COOPERATION IN WHO

This document traces the evolution of the concept of technical cooperation in the United Nations system and in the World Health Organization. It demonstrates that: (1) "technical cooperation" in WHO is fundamentally different from "technical assistance"; (2) WHO's technical cooperation and coordinating functions are mutually supportive; and (3) technical cooperation and coordination together form the inseparable essence of WHO's unique constitutional role in international health work. These two mutually reinforcing constitutional functions are essential for reaching WHO's main social target over the next two decades, the attainment of "health for all by the year 2000".

Examples are presented in Annex I to illustrate how success in international health work can result from the balanced and integrated fulfilment of WHO's coordinating and technical cooperation functions, and from the close identification between the work of WHO and the work of Member States.

The comments and resolutions of the Regional Committees that have reviewed the first draft are presented in Annex III.

The document is presented to the Programme Committee for its comments and recommendations; it is proposed to submit it to the sixty-seventh session of the Executive Board in January 1981 revised as necessary to reflect the deliberations of the Programme Committee.

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Introduction

1. The term "technical cooperation" has become a common part of the vocabulary of the United Nations system and WHO in recent years. The importance ascribed to it in WHO is illustrated by the fact that the very first section of the Handbook of Resolutions and Decisions of the World Health Assembly and the Executive Board, Volume II (1973-1978) is entitled "Policy and Guiding Principles for Technical Cooperation". That section contains two particularly significant resolutions: the first, Health Assembly resolution WHA29.48, required a substantial increase in the percentage allocation of WHO regular budget resources to "technical cooperation and provision of services". The second resolution, WHA30.43, adopted by the Health Assembly in May 1977, took a giant step forward by calling on WHO and Member States to collaborate, and to mobilize and transfer resources for health, in pursuance of the main social target of governments and WHO in the coming decades, namely, "the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life", popularly known as "Health for all by the year 2000". This resolution has profound implications for the meaning of technical cooperation in WHO in relation to the Organization's first constitutional function "to act as the directing and coordinating authority on international health work".

2. When the Executive Board developed and the Health Assembly approved in resolution WHA30.30 a new policy and strategy for the development of technical cooperation,¹ WHO adopted a purely "pragmatic identification"² of technical cooperation for purposes of monitoring compliance with the budgetary target set by resolution WHA29.48, but at the same time recognized the need for a "conceptual definition"³ of technical cooperation that would relate to the reorientation of all the future programmes and workings of WHO. The Executive Board considered that the conceptual definition of technical cooperation was an evolving concept deserving further study.⁴ The relevant extracts concerning the pragmatic identification and conceptual definition of technical cooperation from the report of the Executive Board, at its fifty-ninth session, on the proposed programme budget for 1978-1979, are presented as Annex II to this document. The need for further study of the meaning of technical cooperation in WHO is highlighted by the diverse attitudes of some governments towards technical cooperation in WHO. Some governments have sought to separate "technical cooperation" or "technical assistance" activities from other activities of WHO with a view to denying regular budget funding for technical cooperation or assistance. Other governments have sought to identify separately "technical cooperation activities" within the WHO regular budget with a view to allocating a given percentage of WHO resources to such activities. Finally, many Member States may have assumed that "technical cooperation" is simply qualitatively improved "technical assistance".

¹ WHO Official Records No. 238, Part II, pages 114-123, and 165-225.

² Ibid., pages 116-117, paragraphs 12-13.

³ Ibid., pages 117-118, paragraphs 15-16.

⁴ WHO Official Records No. 238, Part II, page 118, paragraph 16 (2).

3. From the above it is evident that there is a need to reach understanding on the meaning and significance of technical cooperation in WHO. To do this, it is necessary to give a brief summary of the relevant historical evolution of the concept of technical cooperation in the United Nations system in general and in WHO in particular. From this review it can be shown that: (1) "technical cooperation" is fundamentally different from "technical assistance"; (2) WHO's technical cooperation and coordinating functions are mutually supportive; and (3) technical cooperation and coordination in WHO are inseparable components of the Organization's unique constitutional role in international health work. Only by bringing together WHO's functions of technical cooperation and of directing and coordinating authority on international health work will the Organization be able to mobilize the will and the resources of all Member States, individually and collectively, to attain "Health for all by the year 2000". From this it will be seen that mutually supportive coordination and technical cooperation is emerging as the very essence of WHO's international health work.

Technical assistance

4. The United Nations system functions both at the international and the national level. The influence on national activity of the United Nations system's activities at the international level has always been a delicate issue. Technical assistance, as a manifestation of the system's activities at the national level, has, however, been accepted practice since early days. This form of assistance was provided for the economic and social development of the developing countries. As these increased in number as a result of the process of decolonization, the volume of technical assistance provided by the United Nations system also increased.

5. WHO has also provided technical assistance since its inception. Indeed, one of its constitutional functions is "to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of governments". (Article 2 (d)). From the wording of Article 2 (d) in the Constitution, "upon the request or acceptance of governments", it is clear that WHO was meant to offer assistance to countries only if they wanted it. This technical assistance was provided for in the Organization's regular budget. It has always constituted a major part of the regular budget, in contrast to most other specialized agencies which depend largely on special funds for their technical assistance activities. At first, the United Nations Development Programme was the main source of such funds, although in more recent years other bodies such as the World Food Programme, the United Nations Children's Fund, the Office of the United Nations High Commissioner for Refugees, and the United Nations Fund for Population Activities, have disbursed growing proportions of the total technical assistance provided by the United Nations system.

6. What form did the technical assistance provided by the United Nations system take? It consisted mainly of assistance projects funded by the system and executed by one of its specialized agencies - the executing agency. The countries concerned were therefore not really involved in determining the nature of the projects or the way they were carried out; they were passive recipients. Projects were selected, often for demonstration purposes,

in an isolated manner. That is, they did not fit into an overall pattern that reflected the country's main socio-economic preoccupations and potential economic capacities. Rather than responding to the needs of the countries concerned, these projects often represented the interests of the donors and the executing agencies, however well-meaning they were.

7. WHO's technical assistance was in all too many cases no exception to the above situation. The result was the pursuit of many technical projects that often lay outside the main stream of the country's health system and were carried out in such isolation from one another that they did not contribute to the strengthening of the health system as a whole. In addition, projects in one country were often not related to projects in a similar field in other countries. To sum up, particularly through the period of the first United Nations Development Decade, technical assistance was provided through funds, material and personnel donated for agencies to carry out projects in countries for these countries. When the assistance came to an end these projects often left no lasting impact in the country.

Country programmes

8. In the early seventies it became evident that the fragmented project assistance approach was not being effective. Following the Study of the Capacity of the United Nations Development System ("the Jackson Report"), the concept of the country programme arose. This implied a review of the total social and economic development needs of the country concerned, and the attempt to formulate and execute development projects in response to these needs. However, the accent was still on projects for execution by the United Nations system, and not by the countries themselves. The countries' planning resources were involved in working out the country programme, but this was a United Nations country programme, and its implementation remained the domain of external executing agencies.

9. At this juncture WHO adopted an approach that was very different from the above. It was called country health programming. This is a national process aimed at developing, and activating the implementation of, a country-wide health programme that includes the countries' main health priorities. From the outset, it stressed the multisectoral nature of health development, and therefore the need to involve other sectors in the country, wherever relevant, in the planning and programme formulation process. WHO developed a method of health planning which, though by no means simple, was much simpler than the sophisticated planning methods being advocated at that time. WHO then provided its services at the request of countries for working out the country health programme together with the national health authorities. At the same time, it used the experience gained to improve the methodology. This was thus a change from former practice in a number of interlinked ways. Thus, it aimed at promoting the formulation of plans and programmes for health development by the countries themselves; it did so through cooperation between WHO and the individual Member States concerned; it provided countries with information on practical methods of health planning and up-dated this information in the light of experience gained in the countries; implementation of the programme became a national responsibility no less than its formulation; subsequent WHO participation in executing the programme, or part of it, was in no way a pre-condition for WHO's participation in formulating it.

The changing international political climate

10. During the 1970s the political climate in the world changed radically. New relationships evolved between the developing and the developed countries, and among the developing countries themselves. International structures were called into question, and the idea of establishing a New International Economic Order crystallized. Concepts such as national self-reliance and collective self-reliance assumed growing significance. Increasing and more active participation of developing countries in international life could not take place without affecting their participation in externally supported activities for social and economic development within their own boundaries. In such an environment, the passive acceptance of assistance became an outmoded concept. It gave way to the concept of cooperation.

Technical cooperation in WHO

11. The concept of cooperation is nothing new to WHO. Indeed, it is one of the very foundations of its Constitution. The final paragraph of the preamble to the the Constitution states: "Accepting these principles, and for the purpose of cooperation among themselves and with others to promote and protect the health of all people, the Contracting Parties agree to the present Constitution and hereby establish the World Health Organization as a specialized agency within the terms of Article 57 of the Charter of the United Nations." This cooperation gave rise to the progressive emergence of important international health policies, principles and programmes. Yet, as the Organization evolved, its activities in individual countries tended to assume the form of technical assistance outlined above, based on the assumption of a donor role by WHO and a recipient role by its developing Member States. The need to change this was expressed clearly nine years ago in the Fifth General Programme of Work. This Programme included the following statement:

"In the course of time, as many governments develop their own health manpower and basic health services, the necessity for the provision of long-term advisory and demonstration services will diminish, and WHO's role in relation to direct assistance to countries will then become increasingly cooperative in character."¹

12. Four types of technical cooperation are outlined below:

- technical cooperation between WHO and its Member States;
- technical cooperation among developing countries;
- technical cooperation among developed countries; and
- technical cooperation between developed and developing countries.

Technical cooperation between WHO and its Member States

13. The changes in the international political climate referred to above certainly left their mark on WHO. They helped to crystallize the nature of technical cooperation between WHO and its Member States. This was symbolized, for example, by resolution WHA29.48 which aimed at transferring to countries, for technical cooperation and provision of services, resources from

¹ WHO Official Records, No. 193, 1971, p. 69.

the establishment and the administration. The policy and strategy for the development of technical cooperation that was adopted by the Thirtieth World Health Assembly in 1977¹ explained that technical cooperation between WHO and its Member States was a process whereby Member States cooperate with their Organization by making use of it to define and achieve their social and health policy objectives, through programmes that have been determined by their needs and that are aimed at promoting their self-reliance for health development. WHO's role in technical cooperation between itself and its Member States is thus to support national health development. As a corollary to this principle, it is clear that to be effective, WHO's activities must have a positive and lasting influence on countries. Even after WHO has left the scene these activities should have contributed to the establishment, maintenance and growth of national activities that promote and sustain the health of the people concerned.

14. This was the rationale for the criteria for technical cooperation between WHO and its Member States that were included in the policy and strategy for the development of technical cooperation mentioned above. According to these criteria, the nature of technical cooperation must be such as to have "a high degree of social relevance for Member States in the sense that they are directed towards defined national health goals and that they will contribute directly and significantly to the improvement of the health status of their populations through methods that they can apply now and at a cost they can afford now." In formulating these activities, the important principle in technical cooperation of developing national self-reliance in matters of health always has to be kept in sight. In accordance with this principle the concept of WHO doing something for countries has to be abandoned and replaced by cooperation with countries and the fostering of cooperation among the countries themselves so that together a lasting impact is made on health development.

15. Technical cooperation between WHO and its Member States thus implies true partnership to attain national health goals that have been defined in countries by countries. These goals are attained through action that can be sustained and developed further by the Member States themselves when the involvement of WHO and of other Member States is no longer required. In consequence, national programmes receiving WHO support, and any projects that form part of them, should be executed to an increasing extent by the government and by national staff of the country concerned.

16. While technical cooperation is carried out mainly in individual countries, some cooperative activities may be of an intercountry or interregional character, if this is a useful and economical way of satisfying the needs of a number of countries that have similar problems.

17. Technical cooperation of this nature is a far cry from time-limited assistance projects. Its support to programmes is conducive to the further development of these programmes by countries themselves. Such cooperation has a longer term perspective, based on the current

¹ WHO Official Records, No. 238, pp. 114-123 and 181-209.

and future needs of countries, for it seeks to identify appropriate solutions to health problems for the population as a whole, even if these solutions have to be applied progressively to ensure their ultimate equitable application. In this connexion, it should be noted that an important aspect of technical cooperation between WHO and its Member States is the Organization's participation, as required and requested by governments, in the planning, organization and evaluation of nation-wide health programmes, whether by the country health programming process mentioned above or by any other suitable process. This type of activity not only enables countries to select the activities they should undertake to solve their priority health problems; it also helps to determine the fields of application of collaboration with WHO and other cooperating agencies. Among other things, it helps to identify the country's health research needs, and this can be a useful basis for relevant action in the field of health research, leading to the strengthening of national health research capability.

18. The new process of programme budgeting of WHO's resources at the country level serves to complement the national process just mentioned by identifying together with the government the most relevant programmes and the most appropriate activities within these programmes for WHO's cooperation. The unique feature is stressed of financing the major part of this cooperation through WHO's regular budget, as was the case for technical assistance in the past. As mentioned in paragraph 5 above, the basis for this unique feature is the Organization's very Constitution.

19. Technical cooperation of the nature outlined above can thus be the key to wise investments in health by the country itself and, at the request of that country, by WHO and by others in the international community. Another unique feature of such investments by WHO, as will be shown below, is that the policy and principles on which these investments are based are decided upon collectively by the Organization's Member States themselves. Such cooperation between WHO and its Member States can facilitate self-reliant national health development, since what it generates gives rise to sustained investments and accompanying developmental action under the control of the Member State concerned. This applies to developing and developed countries alike. Lest there be any doubt about the latter, recent examples of cooperation between WHO and two highly developed countries are the joint generation and selection of information on health planning methodology, and the request for support in devising a national cancer control programme.

Technical cooperation among developing countries (TCDC)

20. Thus far consideration has been given to technical cooperation between WHO and its Member States. This is not the same as TCDC. TCDC, as its name implies, means cooperation between two or more developing countries. This cooperation is for the purpose of social and economic development and is part of the drive of these countries towards individual and collective self-reliance. The concept was widely discussed at the United Nations Conference on TCDC held in Buenos Aires in the second half of 1978. This Conference considered TCDC as a vital force for initiating, designing, organizing and promoting cooperation among developing

countries so that they can create, acquire, adapt, transfer and pool knowledge and experience for their mutual benefit and for achieving national and collective self-reliance, which are essential for their social and economic development.

21. TCDC for health was widely discussed in preparation for and during the Technical Discussions at the Thirty-second World Health Assembly in May 1979. At these discussions, it was stressed that to achieve this purpose in the field of health each country must examine its own needs, review existing resources and capabilities and, through discussion and mutual agreement with neighbouring countries, propose ways and means for the exchange and transfer of specific resources which lend themselves to cooperative activities and joint ventures, such as the following: training and research; exchange of information and experience on health care; production, procurement and distribution of essential drugs and medical equipment; development and construction of infrastructural facilities such as training schools for health personnel, health centres and hospitals, laboratories and medical libraries; development of low-cost technology for water supply and wastes disposal.

22. TCDC for health may take place without WHO involvement. At the same time, WHO has a duty to support countries in their cooperative endeavours for health. An outstanding recent example is the decision of the countries of the South Pacific, at a Conference of their Ministers of Health, to establish a South-Pacific Pharmaceutical Service, including a Joint Purchasing Office; a warehouse for centralizing the reception, storage and distribution of drugs purchased; a quality assurance unit; and a drug information service. They requested WHO to provide them with technical support in reaching an agreement among themselves.

23. Many other possibilities for TCDC relate to the health activities of political or geographical groupings of countries, for example the Non-Aligned Countries Movement. WHO stands ready to support these endeavours through ensuring timely and appropriate exchanges of information among countries interested in the possibility of cooperating among themselves. This could also include information from related sectors, for example through maintaining contacts with the Information Referral System for TCDC of the United Nations Development Programme. Other kinds of support might include making available expertise on such matters as commercial and legal questions involved in TCDC agreements. Whereas the financing of TCDC activities should be mainly the responsibilities of the countries themselves, WHO may provide for indispensable technical and administrative overhead costs.

Technical cooperation among developed countries

24. The developed countries have cooperated among themselves on health matters for many decades. At first emphasis was laid almost entirely on preventing the international spread of communicable diseases. WHO became involved in these efforts from its very beginning. Indeed, in the immediate post-war period, when the developed countries represented a high proportion of the Organization's membership, support to cooperation among them was one of the Organization's main preoccupations.

25. The criterion that was laid down in the Sixth General Programme of Work, whereby WHO's programmes should give priority to problems of developing countries, did not mean that WHO support to cooperation among developed countries came to an end. On the contrary, WHO continues to be an active catalyst of cooperation among these countries with respect to a wide range of health problems of particular interest to them. These include, to give a few examples, the assessment of the usefulness of selective health screening for early detection of disease; research into the epidemiology and control of cardiovascular diseases in communities; research into the epidemiology and control of cancer; the control of environmental hazards, particularly in industrial areas and international waterways; the long-term health effects of chemicals in the environment; the study of psychosocial factors affecting health; prevention and control of alcohol and drug abuse; the prevention of road traffic accidents; and the care of the aged. The lessons being learned from these activities are made available to all countries - developed and developing.

26. Such cooperation has often taken the form of intercountry activities carried out under the aegis of WHO at minimal cost to the Organization. WHO also maintains technical relationships with geo-political groupings of developed countries, such as the Council for Mutual Economic Assistance (CMEA) and the European Economic Community (EEC).

Technical cooperation between developed and developing countries

27. Yet a fourth type of technical cooperation for health is technical cooperation between developed and developing countries. Such cooperation has been a feature of international health for many decades, although until recently it has mainly taken the form of technical assistance. In recent years there has been a growing trend for developed countries to consult both developing countries and WHO before deciding on bilateral and even multi-bilateral, support for health programmes in the developing countries. This is a new form of trilateral or multilateral cooperation for health development, which is in keeping with the principles of the New International Economic Order.

WHO's coordinating function

28. The first of the Organization's twenty-two constitutional functions is "to act as the directing and coordinating authority on international health work". Whereas WHO's technical cooperation is primarily a process of two-way action between WHO and its Member States, WHO's coordinating function in international health is carried out primarily through the collective action of its Member States. This collective action takes place in the Health Assembly, the Board, and the Regional Committees, with the support of the Secretariat, as prescribed in the Constitution. These structures are supported by a wide range of mechanisms for providing scientific, technical and managerial expertise, whose generation or synthesis WHO coordinates on a world-wide scale. The application by individual Member States of policies and principles adopted collectively by them in WHO illustrates well the voluntary acceptance of the Organization's leadership role in international health work. This role is a striking expression of direction and coordination, a function of WHO made possible by the fact that it is fulfilled through the collective action of Member States.

29. The Sixth General Programme of Work, recognizing the pride of place given in the WHO Constitution to the coordinating function, stated that coordination implies, essentially, WHO leadership aimed at bringing to bear the right solution on the right problem with the right amount and quality of resources at the right time and place.¹ It thus lies within the Organization's coordinating function to identify health problems that deserve high priority and for whose solution international action is required. The Sixth General Programme of Work laid stress on the complementarity of WHO's activities and priority national health programmes. It emphasized the problems of countries least capable of finding solutions on their own. As for the right solutions, these include the formulation of socially relevant health policies, principles, strategies, plans of action and programmes, and the reaching of agreement on the best ways of carrying them out. The Sixth General Programme of Work advocated the definition of guiding principles and their adaptation to local circumstances and cultures. It stressed that the resources should be first and foremost those of the countries concerned, WHO's resources aiming to develop national resources, not to supplant them. The right place for WHO's activities was identified as being within countries, activities at other levels supporting country endeavours. As for the right time, the Programme advocated a forward looking approach.

30. WHO's coordinating function can thus be seen to encompass the identification of priority health problems throughout the world and the formulation of international health policies, in response to these problems. It includes defining principles, capable of local adaptation, for interpreting policies and the development of international strategies, plans of action and programmes for giving effect to these policies. It also includes the reaching of agreement on priorities for implementation. In support of the above, the Organization's coordinating function encompasses the promotion of health research and development, and the definition of the scientific and technical bases for health programmes, including norms and standards. It does so through identifying the world's most important health research goals and promoting the collaborative efforts of the world's most suitable health research workers to fulfil these goals. WHO coordinates the definition of norms and standards in a variety of fields, such as food, biological and pharmaceutical standards, diagnostic procedures and international nomenclature and classification of disease. As part of its coordinating function the Organization tries to match needs in some countries with resources in others and in the collectivity of Member States that WHO is, and to mobilize, rationalize, and secure the international transfer of resources accordingly. The coordinating function also includes the strengthening of relationships with international non-governmental organizations working in the health sector. In addition, it includes joint action with other sectors at the international level, both inside and outside the United Nations system, in common endeavours for health and socioeconomic development.

¹ WHO Official Records, No. 233, Annex VII, p. 73.

31. An important aspect of WHO's coordinating function is the generation and international transfer of valid information on health matters, the Organization serving as a neutral ground for absorbing, distilling, synthesizing and disseminating information that has practical value for countries in solving their health problems. In this way, WHO can provide the world with an objective assessment of what is really valuable for health development, and it can identify those health problems for which there is as yet no suitable answer. The Organization also has an important role in ensuring the proper use of this information; this role is described in paragraphs 35 and 36 below.

WHO's international health work

32. The Organization's coordinating and technical cooperation functions can on no account be considered as being separate. Through its directing and coordinating function the most relevant health goals for Member States and the most suitable ways of attaining these goals are defined collectively by Member States at regional and global levels. These goals and ways of attaining them then form the most useful basis for technical cooperation activities between Member States and WHO and among themselves. But technical cooperation involving true partnership to attain well-defined national health goals is the best way to lead to the identification of relevant international health goals and of appropriate ways of attaining them. It can be seen, therefore, that collective decisions taken in WHO through its coordinating function make technical cooperation between the Organization and its Member States more relevant; and good technical cooperation between WHO and its Member States facilitates the fulfilment of the Organization's coordinating function. So, if the Organization's coordinating and technical cooperation functions are properly carried out, they become mutually supportive and intimately interwoven to the extent that any distinction between them becomes artificial and blurs the real nature of the international health work the Organization performs in accordance with its Constitution.

33. Where technical cooperation among countries as described in paragraphs 20 to 27 above is carried out with and through the involvement of WHO, whether in the form of technical cooperation among developing countries, among developed countries, or between developed and developing countries, such technical cooperation is really an integral part of WHO's function of coordination. This serves as another illustration of how these two functions are closely interlinked within WHO's international health work.

34. The progressive evolution of this process of supportive interaction between the Organization's coordinating and technical cooperation functions dates back to the Fifth General Programme of Work, which was approved by the Twenty-fourth World Health Assembly in May 1971. This was the first General Programme of Work that attempted to concentrate the Organization's activities on the attainment of a limited number of defined principal programme objectives. It was immaterial whether these activities could be classified under coordination or technical cooperation. This focussing of activities stood in contrast to previous practice, which consisted rather of presenting catalogues of activities generated by fragmented

interests. The Sixth General Programme of Work took the process a step further in attempts to strengthen the cohesion of activities carried out as part of WHO's coordinating and technical cooperation functions. As will be shown below, a leap forward in this process was taken in 1977 when the Thirtieth World Health Assembly adopted the target of health for all by the year 2000.

35. The Organization's role with respect to information transfer also illustrates the inseparability of its coordinating and technical cooperation functions. The coordinating function includes capitalizing on WHO's impartiality to ensure the availability of valid information that will permit Member States to make rational decisions on health technology and on health systems. To ensure that information is valid demands a willingness on the part of Member States to participate in its generation and selection, and a readiness to use it however much it may contradict existing beliefs and dogmas. The generation and use of such information is the key to the international transfer of appropriate technology, which should encompass the whole of health technology, aiming at generating acceptable technology that can easily be applied by the health system, no matter how complex the research required to generate it. As mentioned in paragraph 31 above, it is the Organization's duty to ensure not only that the most valid health information is collated, analysed and adequately disseminated, but also that this information is properly absorbed by those who require to use it. This last aspect forms part of WHO's technical cooperation functions, and the complementarity of these two aspects of information transfer illustrates well the mutually enhancing nature of the Organization's two major functions of coordination and technical cooperation.

36. The insistence of Member States on WHO using the information it has found valid, and making sure that whoever sets foot in any Member State on the Organization's behalf uses it also, is the key to ensuring that technical cooperation between Member States and WHO will be based on the best standards, even if these are not always the ones that are conventionally applied. And if, in addition, before Member States request technical cooperation, they make sure that the subjects of such cooperation are highly relevant to their strategies for attaining health for all their people, this will go far towards ensuring that WHO's coordinating and technical cooperation functions are used in such a way as to provide mutually enhancing support whatever its nature and whatever its source.

Strategies for health for all by the year 2000

37. The most outstanding expression of the mutual reinforcement of WHO's coordinating and technical cooperation functions is the development of strategies for health for all by the year 2000. After having been considered in the Regional Committees, the goal of health for all by the year 2000 was agreed upon collectively by all Member States when the Thirtieth World Health Assembly adopted resolution WHA30.43 in May 1977. This resolution appeared under the title of technical cooperation. Thus, preoccupation with technical cooperation led the Health Assembly to adopt a resolution that had the most far reaching implications for WHO's directing and coordinating function! For, when the Health Assembly took this momentous

decision it also gave an entirely new dimension to international health work. To attain this target, unprecedented efforts in the field of health have to be made nationally and internationally. International efforts have to support national efforts as never before, but national efforts are required both to identify the international support required and to make the best use of it. In the light of the Health Assembly's decision, WHO's international health work now consists essentially of the mutual reinforcement of its coordinating and technical cooperation functions, to support Member States collectively and individually in developing and implementing national, regional and global health policies, strategies, plans of action and programmes to attain health for all by the year 2000.

38. The current concepts of primary health care, on which the strategies for health for all will be based, were arrived at following an Executive Board Organizational study on basic health services. This was accompanied by WHO learning from countries of their experiences with basic health services, including the identification by them of the inherent weaknesses. In this way the Organization gained an appreciation of the need for a new approach. This experience, gained from technical cooperation between WHO and its Member States, was put to use in preparing for the International Conference on Primary Health Care held in Alma-Ata in 1978. At this Conference - an outstanding example of WHO's coordinating function together with UNICEF - agreement was reached on the principles of primary health care as the key to attaining health for all by the year 2000. No prescriptive world strategy was formulated at Alma-Ata. It was clear that any such strategy must be based on national strategies.

39. The above principles were later approved by the Thirty-second World Health Assembly, which, in applying the Organization's coordinating function, invited Member States in resolution WHA32.30 to consider the immediate use of the document entitled "Formulating Strategies for Health for All by the Year 2000" that had been prepared by the Board, individually as a basis for formulating national strategies, and collectively as a basis for formulating regional and global strategies. Countries have now embarked on the preparation of these strategies. WHO is supporting countries individually in this endeavour on request, in fulfilment of its technical cooperation function. It is also supporting them in groups through intercountry workshops, an example of technical cooperation at the intercountry level. But the regional and global strategies, and subsequent Programmes of Work of WHO, in support of individual national strategies, will be arrived at through the application of WHO's coordinating functions, for they will be the result of collective decisions in the Regional Committees and the Health Assembly. The use of these regional and global strategies to support the implementation of individual national strategies on the request of the government concerned will be ensured through WHO's technical cooperation function.

40. It can be seen that the adoption on a global scale of interrelated policies and strategies at national, regional and global levels for "health for all by the year 2000" has profound implications for the meaning of technical cooperation and its relation to WHO's

coordinating function in international health work. In the past, WHO's work consisted of relatively little "coordination" in the full constitutional sense, and of a large amount of "technical cooperation" that was not necessarily related to activities being carried out as part of the function of coordination. The new goal of "Health for all by the year 2000" changes this pattern, for WHO is now called upon to exercise fully its constitutional function of coordination. Thus, the Organization has to direct and coordinate the formulation of health policies, strategies, plans of action and programmes for attaining this goal. Such coordination is essential if regional and global strategies are to be prepared in such a way as to support national strategies. At the same time, technical cooperation between WHO and its Member States has to aim at ensuring optimal formulation and implementation of national strategies, and optimal application of regional and global strategies in support of national strategies. To do so successfully means that all future WHO technical cooperation at all levels must be closely related to the Organization's coordinating function in international health work, and that this coordinating function must generate the ideas, the information and the resources required for optimal fulfilment of the Organization's technical cooperation function. The new WHO policy and strategy for "health for all by the year 2000" thus make it impossible to separate technical cooperation from coordination, since each is supportive and integral to the other, and together constitute WHO's international health work.

41. There can be no better illustration of the artificial nature of any separation between WHO's technical cooperation and coordinating functions. They are both mutually reinforcing aspects of WHO's international health work. If this international health work is to be effective, it must never again be fragmented and separated into unrelated compartments. It must be pursued by Member States individually and collectively as envisaged in the Constitution, namely "for the purpose of cooperation among themselves and with others to promote and protect the health of all peoples."

ILLUSTRATIVE EXAMPLES OF WHO'S INTERNATIONAL HEALTH WORK

1. The following examples serve to illustrate how WHO's international health work combines its coordinating and technical cooperation functions, and how the research and development components of its programmes complement their operational components and are in turn complemented by them.

Smallpox eradication

2. In 1966 the Member States of WHO decided in the Health Assembly to intensify the global smallpox eradication programme. In 1967, a draft technical guide was prepared. It outlined general principles, namely the need for surveillance and for vaccination programmes employing good quality freeze-dried vaccines. It was made clear that no single blueprint could be universally applicable in view of vast differences in national health policies and structures, personnel, population characteristics and attitudes, geography and climate. Alternative methods and procedures for programme execution were described and WHO staff as well as national health administrations were actively encouraged to evolve others. The need was emphasized for each country to develop and to continue to evolve its own scheme or schemes appropriate to the particular conditions obtaining in the various parts of its territory. This included widespread efforts to facilitate the exchange of experiences. In consequence, although surveillance and vaccination were common to all national eradication programmes, no two programmes were identical and the differences between some of them were very great indeed.

3. Early in the global programme, the development of surveillance activities, if necessary at the expense of mass vaccination, was demonstrated to be the most effective approach in Western Africa and Indonesia and this approach was then adopted universally; a simplified scheme of vaccination assessment that had been developed in Afghanistan was subsequently employed in most countries; the Indonesian programme assisted by the WHO Regional Office for South-East Asia originated the Smallpox Recognition Card which later became universal; the idea for and methodology of area-wide search that was employed throughout the endemic zones of Asia were initiated by a WHO country adviser and his Indian counterparts. Such examples are but a few of many.

4. Another facet of the overall strategy was the coordination of assistance provided from various bilateral sources. Every effort was made towards full harmonization of WHO and bilateral contributions. In brief, the programme strategy and pattern of execution evolved as a result of closely coordinated interrelationships between WHO's various operational levels and the national health administrations and other supporting agencies, and not as a result of a central master plan imposed by some authoritative central or regional hierarchy.

5. The above illustrates how WHO's coordinating function was used to develop policies, principles, and scientific and technical bases, and how these were applied in WHO's technical

cooperation with individual countries. This technical cooperation in turn led to improvements in methods which were made universally available through WHO's coordinating information exchange function.

Research on Human Reproduction

6. The Special Programme of Research, Development and Research Training in Human Reproduction was established in 1972 in response to requests made in resolutions of the World Health Assembly and by individual Member States. Scientists and research administrators from 70 countries - 45 of them developing countries - are now cooperating in the Programme's activities. These have two main objectives:

- to strengthen national capabilities for research in human reproduction in order to enable developing countries to plan and to carry out research, adapt technology and contribute fully to the advancement and application of science; and
- to promote collaborative research on the safety and efficacy of current methods of fertility regulation, the development of new methods, psychosocial and social aspects of family planning, and the diagnosis and treatment of infertility.

7. The management of research in the Programme is carried out on a cooperative basis. Its strategy is formulated and the research planned, reviewed and evaluated by policy makers, scientists and research administrators from 44 countries, of which 28 are developing countries. This is achieved through a number of interrelated mechanisms, including the Advisory Group to the Programme, the meeting of Member States contributing to it, the Review Group, the Toxicology Review Panel, the Steering Committees of Task Forces and the Committee on Institution Strengthening. In addition, an annual coordinating meeting is held to which the Programme convenes the major agencies conducting or directly supporting research in human reproduction. The Programme is regularly reviewed by the World Health Assembly and the Global and Regional Advisory Committees on Medical Research.

8. Research in the Programme is carried out on a collaborative basis, which takes two forms: one may be termed "horizontal", in which institutions from different countries conduct the same study using a common protocol, in order to provide results rapidly, obtain data from inter-population comparisons and at the same time collect information of immediate local relevance. The "vertical" collaboration consists in groups of scientists working on a common problem and within a defined strategy, but attacking different aspects of it.

9. These two aspects are well illustrated by research relating to intra-uterine devices (IUDs). This method of birth control is presently used by about 60 million women in all parts of the world. The large number suggests that it is an acceptable form of family planning, but it does not reflect the fact that many women give up using it after one or two years. Many different types of IUD are available. They come in different shapes and

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different materials. It would take many years to obtain enough data in any one centre to answer the requests for advice frequently made to the Programme by Member States concerning the type of device to include in their national family planning programme. Moreover, these results may only be applicable to that particular population.

10. The Programme therefore coordinated research activities in centres in 20 countries to compare plain plastic with copper-releasing IUDs. It was found that the device most commonly used in family planning programmes, the Lippes Loop, performed less well than the copper-releasing device, resulting in more expulsions, more pregnancies and more removals for pain and bleeding. The Lippes Loop caused greatly increased menstrual blood loss, compared with pre-insertion levels. Women in developed countries, with adequate nutrition, may easily make up for this blood loss. In developing countries, however, the Programme's studies have shown that it could lead to progressive depletion of iron stores and to anaemia.

11. These results have been widely disseminated, in particular to national family planning programmes and to bilateral and multilateral agencies providing support to family planning in developing countries. The findings, emerging from "horizontal" collaborative research, also led to two quite different lines of "vertical" multidisciplinary cooperative research:

- one, at the more physiological level, to learn more about mechanisms of IUD-induced bleeding so as to identify drugs that might be used to reduce it;
- the other, at the more bio-engineering level, to improve on the performance of devices by loading plastic IUDs with a contraceptive steroid.

12. Among the new facts that have emerged from the first set of studies, one of particular significance is that mechanisms of clotting in the endometrium in the presence of an IUD are different from those anywhere else in the body. These findings have allowed the identification of drugs that counteract bleeding and that can be given orally or incorporated in an IUD.

13. The second set of studies focussed on "loading" IUDs with a hormone which would be slowly released and allow the size of the IUD to be reduced, thus avoiding pain and excess bleeding and at the same time maintaining a high level of efficacy. It was found that the hormone in fact reduced bleeding to below pre-insertion levels. These new IUDs are now becoming available.

14. The studies mentioned so far relate to the safety of current IUDs and the development of improved ones. Other studies in the Programme, also conducted on a collaborative basis, deal with the equally important aspect of the delivery of IUDs at the service level. In many countries, insertion of an IUD has been the prerogative of the gynaecologist. This has greatly limited the use of IUDs in developing countries and practically ruled it out in rural areas. It was felt by some that midwives could perform this task given appropriate

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training, but there was considerable resistance from the medical establishment. A group of gynaecologists from different countries was therefore brought together by the Programme, and it defined the knowledge and skills required to insert IUDs. Manuals were prepared and used in the training of midwives, whose performance was then compared in carefully designed studies with those of physicians. To date, the midwives have performed as well or better than physicians. They can acquire the necessary skills and knowledge and have the added advantage of being much closer and more accessible to the population.

15. The scientists involved in the different types of research mentioned above come from Brazil, Canada, Chile, China, Colombia, Cuba, Egypt, Hungary, India, Japan, Nigeria, New Zealand, Philippines, Republic of Korea, Singapore, Sweden, Thailand, Tunisia, USSR, United Kingdom, USA, Vietnam, West Berlin, Yugoslavia, and Zambia.

Research on Malaria

16. The Special Programme of Research and Training in Tropical Diseases was established in 1975 by decision of the World Health Assembly, it is co-sponsored by the United Nations Development Programme, the World Bank, and WHO, which is the Executing Agency. It has two objectives:

- research and development towards new and improved tools to control six tropical diseases; and
- training and strengthening of national institutions to increase the research capabilities of the countries affected by the diseases.

17. One of the diseases being dealt with by the Programme in Tropical Diseases together with the Malaria Action Programme is malaria. A serious and urgent problem for malaria control that was identified some years ago in certain countries in parts of Asia and the Americas, and that may also be spreading into Africa, is the resistance of Plasmodium falciparum to chloroquine and other 4-aminoquinoline drugs. It is clearly important for countries to know whether such resistance indeed exists, and, if it does, what alternative measures are available. To arrive at this information, and to learn from one another's experience, international collaborative research was initiated with a view to arriving at standard methods of identifying the existence of such resistance, and to finding alternative solutions.

18. In the light of methods for monitoring drug resistance developed by the Programme of Malaria, the Special Programme in Tropical Diseases is tackling the problem on a global scale through collaborative research involving more than 20 countries. This research has been developed in consultation with the scientists and the representatives of national malaria control programmes, at regional workshops, and at meetings of the global scientific working group on applied field research in malaria.

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19. The objectives of the research are:

- to assess P. falciparum sensitivity to 4-aminoquinolines;
- to monitor the spread of resistance; and
- to devise mechanisms for the containment of the spread and eventually for the reduction and elimination of the foci of drug-resistant P. falciparum.

20. It became apparent that the pursuit of this research required its own training. In consequence, since November 1977, more than 200 scientists and technicians from 40 countries have been trained in interregional, regional and national courses in modern methods for determining the susceptibility of P. falciparum to drugs, both in vivo and in vitro. These courses have taken place in Benin, Brazil, Colombia, El Salvador, Malaysia, Mozambique, Sudan, Switzerland, Tanzania, and Thailand. Standard kits for the in vitro test are being manufactured in the Philippines and their quality is regularly controlled in the Communicable Disease Centre in Atlanta, United States of America. These kits are distributed to the national institutions and scientists collaborating in the research. Currently, surveys are being conducted in a number of countries to map out the distribution of drug-resistant parasites. These investigators will meet periodically to exchange technical information.

21. An improved microtechnique, using only a few drops of blood, is being evaluated by a number of scientists in various parts of the world. Eventually, the microtechnique should be available in kit form and would replace the present standard method.

22. The results of the above research will be made available to all countries, and will be used by the countries concerned as part of their malaria control strategy. If requested, WHO will cooperate with these countries in applying the new knowledge.

23. It can be seen that the Special Programmes of Research in Human Reproduction and Tropical Diseases and the Malaria Action Programme are based on health problems that have been identified in the countries affected, often by the countries themselves. The research is agreed upon and conducted as an international collaborative effort within WHO's coordinating function. By means of this function WHO has organized the world scientific community to tackle the problems, drawing on the human resources of developing and developed countries alike, as well as those of its own secretariat. The Programmes generate knowledge and technology of immediate social relevance and promote self-reliance in health research in developing countries. The results of the research are applied in countries, predominantly developing countries but also developed ones. When WHO is asked to participate in the application of the research findings, it does so by means of its technical cooperation function, using information generated through its coordinating function. Thus, the Organization's research, information and technology transfer, and operational functions are closely interlinked and mutually supportive.

THE PRAGMATIC IDENTIFICATION AND CONCEPTUAL DEFINITION
OF TECHNICAL COOPERATION

Extract from the report of the Executive Board at its fifty-ninth session,
on the proposed programme budget for 1978-1979 (financial year 1978)¹

Pragmatic identification

12. The Executive Board recognized that it was dealing with two issues: (1) the guiding concept of technical cooperation for purposes of reorienting all the future programmes and workings of WHO towards increased, relevant technical cooperation in accordance with the spirit of the Assembly resolution; and (2) the pragmatic identification of technical cooperation activities for purposes of measuring the shift of regular budget resources towards direct technical cooperation to meet the specific 60% target set by resolution WHA29.48. Members stressed that, in seeking a conceptual or philosophic definition of technical cooperation, care should be taken not to bias the pragmatic identification required for honest measurement of compliance with the 60% target set by resolution WHA29.48. This was why the Director-General, in his proposed policy and strategy paper, had continued to use the same cautious and pragmatic approach to the identification of activities devoted to technical cooperation as had been taken in developing the baseline information on the level of technical cooperation in 1977 (i.e. 51.2%) presented in Official Records No. 231, on which the Health Assembly had apparently relied when it set the 60% target contained in resolution WHA29.48. The only addition which the Director-General had made to this baseline in his strategy proposals was that four new programmes considered unequivocally to be technical cooperation - namely, Emergency Relief Operations, Expanded Programme on Immunization, Special Programme for Research and Training in Tropical Diseases, and Prevention of Blindness - were included in the technical cooperation figures for 1978-1981.

13. The Board found it useful to refer to the baseline identification of technical cooperation in Official Records No. 231. It was recalled that in January 1976, in order to provide some kind of a baseline by which to assess the order of magnitude of WHO's technical cooperation activities, the Director-General had presented to the fifty-seventh session of the Executive Board a table summarizing, in 1977 budgetary terms, technical cooperation with and services to, governments. For the purpose of that presentation, an extremely cautious and pragmatic approach had been taken to the identification of activities devoted primarily to technical cooperation. Country activities requested by governments, intercountry activities, certain interregional activities physically located or carried out at country level, regional advisers, and WHO representatives' offices in countries were included as technical cooperation, as was the Director-General's and Regional Directors' Development Programme. In addition, fellowships and supply services at regional offices as well as the smallpox eradication programme, pre-investment planning for basic sanitary services, and 80% of the budgetary provision for supply services furnished by headquarters, were considered as technical cooperation. Most other programmes and activities at regional offices and at headquarters were excluded, even though many of them contain a large technical cooperation component or provide support to technical cooperation. This presentation was believed to be useful as a starting point for quantifying the extent of technical cooperation, following the adoption of resolution WHA28.76.

Conceptual definition

15. With regard to the conceptual definition of technical cooperation, the view was expressed that the essential meaning, responding to the spirit underlying resolution WHA29.48, was already contained in the interpretation that had been put forward by the Director-General; this essential concept should be elaborated to provide increasingly specific guidance for the future evolving technical cooperation work of WHO. The Executive Board endorsed the basic conceptual interpretation of technical cooperation stated below:

¹ WHO Official Records, No. 238, 1977, pp. 116-117, paras 12, 13, 15 and 16.

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Technical cooperation means activities which have a high degree of social relevance for Member States in the sense that they are directed towards defined national health goals and that they will contribute directly and significantly to the improvement of the health status of their populations through methods that they can apply now and at a cost they can afford now, and which conform to the principle and aim of developing national self-reliance in matters of health.

16. The Executive Board drew essentially two conclusions from this section of its review of the proposed programme budget policy and strategy for the development of technical cooperation:

- (1) The pragmatic identification of technical cooperation described in paragraph 13 above is an adequate basis for measurement of achievement of the 60% technical cooperation target set by resolution WHA29.48.
- (2) The conceptual definition of technical cooperation, based on the interpretation stated in paragraph 15 above, is an evolving concept deserving further study by the Programme Committee of the Executive Board at its future meetings.

The Board also considered that the concept of technical cooperation as discussed at meetings of regional committees should continue to be reviewed not only by the Programme Committee of the Board but by the Board as well.

COMMENTS AND RESOLUTIONS OF REGIONAL COMMITTEES

The Regional Committee for Africa adopted resolution AFR/RC30/R13 which is attached.

The Regional Committee for the Americas reviewed the matter during their discussion on WHO's structures in the light of its functions, TCDC and the regional strategy for health for all. Particular attention was given to TCDC as a means by which countries could produce a multiplier effect on the development of their health care systems. The role of WHO and other international agencies in promoting and fostering TCDC was clearly identified, particularly in the development of information systems, legislation, and essential drugs, and in the formulation of strategies for the development of TCDC activities.

The Regional Committee for South-East Asia included its comments on the document as operative paragraph 2 of resolution SEA/RC33/R5 on the Study of WHO's structures in the light of its functions. The resolution is attached.

Regional Committee for the European Region: Document DGO/80.3 was circulated to all Member States in the Region prior to the meeting but no comments were made on this subject during the session.

The Regional Committee for the Western Pacific adopted resolution WPR/RC31.R9 which is attached.

Annex III

WORLD HEALTH
ORGANIZATION

RESOLUTIONS
of the
REGIONAL COMMITTEE FOR AFRICA

Thirtieth session

AFR/RC30/R13
22 September 1980

ORIGINAL: FRENCH

THE MEANING OF TECHNICAL COOPERATION IN WHO

The Regional Committee,

Having examined document DGO/80.3 and the report of the Regional Director¹ on that subject,

1. APPROVES the content of the documents;
2. CONFIRMS the relevance of the definition of technical cooperation as formulated in 1977 by the Executive Board at its fifty-ninth session,²
3. NOTES WITH INTEREST AND SATISFACTION the firm and irreversible reorientation of the work of WHO in the African Region towards technical cooperation;
4. WELCOMES the pioneering role played by the African Region in this field;
5. INVITES Member States to use the country health programming approach as the basis of their managerial procedures and thereby facilitate the inclusion of bilateral, multilateral and international cooperation in national development programmes;
6. REQUESTS the Regional Director to develop mechanisms for dialogue between and concerted action and reflexion by the countries of the Region and countries of other Regions and thus strengthen technical cooperation with the aim of attaining health for all by the year 2000;
7. FURTHER REQUESTS the Regional Director to include in the biennial reports on the work of WHO in the Region all relevant information concerning progress made in the field of and on the path to technical cooperation;
8. INVITES the Regional Director and the Director-General to review the structures of WHO in the light of its functions, bearing in mind the concept of technical cooperation as defined by the Executive Board in 1977.

Fifth meeting, 22 September 1980

¹ Document AFR/RC30/16.

² WHO Official Records, No. 238, 1977, pp. 116-117.

RESOLUTION OF THE REGIONAL COMMITTEE FOR SOUTH-EAST ASIA

SEA/RC33/R5

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

The Regional Committee,

Recalling World Health Assembly resolution WHA31.27, on the basis of which the Director-General initiated a study of WHO's structures in the light of its functions with a view to ensuring that activities at all levels promote integrated action, and resolution SEA/RC32/R7 endorsing a study conducted in this region by a Sub-Committee appointed by the Regional Committee at its thirty-first session,

Noting that the Thirty-third World Health Assembly, having considered a comprehensive report by the Director-General including the South-East Asia Regional Study as well as others, recommended a series of actions detailed in its resolution WHA33.17,

Appreciating the fact that such actions need to be urgently implemented for attaining the goal of health for all by the year 2000, and

Having considered a detailed Plan of Action prepared by the Director-General in this regard as well as a document (DGO 80.3) outlining the concept of technical cooperation,

1. ENDORSES the Plan of Action proposed for implementing the recommendations contained in resolution WHA33.17;
2. AGREES with the concepts of technical cooperation as contained in document DGO 80.3;
3. URGES Member States
 - (i) to initiate actions on the recommendations in operative paragraph 2 of resolution WHA33.17, especially that relating to strengthening of the role of ministries of health at the national levels;
 - (ii) to strengthen the role of the Regional Committee in the light of the new tasks devolving on it for the attainment of the goals of health for all by the year 2000;
 - (iii) to ensure representation at the highest level from the Ministry of Health, preferably the Minister of Health, at the Regional Committee, and
4. REQUESTS the Regional Director
 - (i) to initiate necessary actions to carry out studies to bring about the restructuring and reorientation of the Organization at the regional level in the light of the guidelines contained in the Plan of Action;
 - (ii) to strengthen the functioning of the Organization at the country level, and
 - (iii) to take steps to redesignate the WHO programme coordinators as WHO representatives.

WORLD HEALTH ORGANIZATION



ORGANISATION MONDIALE DE LA SANTE

R E S O L U T I O N

REGIONAL COMMITTEE FOR THE
WESTERN PACIFIC

COMITE REGIONAL DU
PACIFIQUE OCCIDENTAL

WPR/RC31.R9
11 September 1980

TECHNICAL COOPERATION AMONG DEVELOPING COUNTRIES

The Regional Committee,

Having considered the report of the Sub-Committee on Technical Cooperation among Developing Countries,¹

1. AGREES with the conclusions of the Sub-Committee with respect to the meaning of the term "technical cooperation" and the mutually supportive role of technical cooperation and coordinating functions, which form the inseparable essence of WHO's unique constitutional role in international health work and are necessary to achieve the goal of health for all by the year 2000;
2. AGREES FURTHER with the recommendations on the primary health care aspects of communicable disease control contained in the report;
3. REQUESTS the Regional Director:
 - (1) to transmit the conclusions of the Sub-Committee on the meaning of technical cooperation to the Director-General to be included in his presentation to the Programme Committee of the Executive Board in November 1980,
 - (2) to take appropriate action to put the recommendations of the Sub-Committee into effect;
4. REQUESTS the Sub-Committee, for its work in 1981, to address the subject of strengthening the mechanisms for technical cooperation among countries.

Fifth meeting, 11 September 1980
WPR/RC31/SR/5

¹ Document WPR/RC31/13.