WORLD HEALTH ORGANIZATION

THIRTY-FIFTH WORLD HEALTH ASSEMBLY

GENEVA, 3-14 MAY 1982

RESOLUTIONS AND DECISIONS
ANNEXES

GENEVA
1982
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
ACMR - Advisory Committee on Medical Research
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 Organization (Office)
IMO - International Maritime Organization
ITU - International Telecommunication Union
NORAD - Norwegian Agency for International Development

OAU - Organization of African Unity
OECD - Organisation for Economic Co-operation and Development
PAHO - Pan American Health Organization
PASB - Pan American Sanitary Bureau
SIDA - Swedish International Development Authority
UNCTAD - United Nations Conference on Trade and Development
UNDP - United Nations Development Programme
UNDRO - Office of the United Nations Disaster Relief Coordinator
UNEP - United Nations Environment Programme
UNESCO - United Nations Educational, Scientific and Cultural Organization
UNFDAC - United Nations Fund for Drug Abuse Control
UNFPA - United Nations Fund for Population Activities
UNHCR - Office of the United Nations High Commissioner for Refugees
UNICEF - United Nations Children's Fund
UNIDO - United Nations Industrial Development Organization
UNITAR - United Nations Institute for Training and Research
UNRWA - United Nations Relief and Works Agency for Palestine Refugees in the Near East
UNSCEAR - United Nations Scientific Committee on the Effects of Atomic Radiation
USAID - United States Agency for International Development
WFP - World Food Programme
WHO - World Health Organization
WIPO - World Intellectual Property Organization
WMO - World Meteorological Organization

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

The Thirty-fifth World Health Assembly was held at the Palais des Nations, Geneva, from 3 to 14 May 1982, in accordance with the decision of the Executive Board at its sixty-eighth session. Its proceedings are published in three volumes, containing, in addition to other relevant material:

- Resolutions and decisions,¹ and list of participants - document WHA35/1982/REC/1
- Verbatim records of plenary meetings, and committee reports - document WHA35/1982/REC/2
- Summary records of committees - document WHA35/1982/REC/3

¹ The resolutions, which are reproduced in the order in which they were adopted, have been cross-referenced to the relevant sections of the WHO Handbook of Resolutions and Decisions, and are grouped in the table of contents under the appropriate subject headings. This is to ensure continuity with the Handbook, Volumes I and II of which contain most of the resolutions adopted by the Health Assembly and the Executive Board between 1948 and 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

WHA35.1 Method of work of the Health Assembly

The Thirty-fifth World Health Assembly,

Recalling the decision in resolution WHA34.29 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;

Recalling also paragraphs 1(8) and 3(1) of resolution WHA33.17;

Having considered the Executive Board's recommendations concerning the method of work to be implemented on a trial basis at the current Health Assembly;¹

1. DECIDES that, notwithstanding the provisions of paragraph 1(1) of resolution WHA32.36, one main committee shall meet during the general discussion in the plenary meetings of the Health Assembly on the reports of the Executive Board and the report of the Director-General on the work of WHO, and that the General Committee, whenever it deems it appropriate, may schedule meetings of one main committee during plenary meetings of the Health Assembly at which other items are discussed;

2. DECIDES that, during the Technical Discussions held at the end of the first week of the Health Assembly, notwithstanding the provisions of paragraph 2 of resolution WHA31.1, plenary meetings of the Health Assembly shall be held all day on Friday and one main committee shall meet on Saturday morning;

3. DECIDES further that the methods of work described in paragraphs 1 and 2 above shall apply initially only during the current Health Assembly, it being understood that the results of this trial will be reviewed by the Thirty-sixth World Health Assembly, as foreseen in resolution WHA34.29;

4. REQUESTS the Director-General, whenever he considers it in the best interest of the Organization and its Member States, to draw the attention of the Health Assembly to the possibility of deferring its consideration of proposed draft resolutions and policy issues involving matters of regional interest, which have not yet been reviewed by the regional committees, until their views and recommendations are available to the Health Assembly.

WHA35.2 Changes in the programme budget for 1982-1983

The Thirty-fifth World Health Assembly,

Having considered the Director-General's report on changes in the programme budget for 1982-1983 and the Executive Board's recommendations thereon;

Recalling previous decisions of the Health Assembly with respect to annual reporting by the Director-General on the work of WHO, biennial budgeting, and interim financial reporting;

Recalling also resolution WHA34.29 limiting the duration of the Health Assembly to not more than two weeks in even-numbered years;

1. DECIDES that the brief review of the changes in the programme budget to be made by the Health Assembly in even-numbered years pursuant to resolution WHA28.69 shall be undertaken by the Executive Board;

2. REQUESTS the Executive Board in even-numbered years to review such changes as may have been made in the approved programme budget for the current biennium when it considers the reports of the Regional Directors on regional committee matters requiring the particular attention of the Board;

3. REQUESTS the Director-General to report to the Board in even-numbered years any significant developments in respect of global and interregional activities, and important changes made in regional programmes, with major implications for the current biennial programme budget.

Hbk Res., Vol. II (4th ed.), 2.2.3; 2.3.10 (Eleventh plenary meeting, 11 May 1982 - Committee A, first report)

WHA35.3 Financial report on the accounts of WHO for the financial period 1 January 1980 - 31 December 1981, and reports of the External Auditor

The Thirty-fifth World Health Assembly,

Having examined the financial report and audited financial statements for the financial period 1 January 1980 - 31 December 1981 and the reports of the External Auditor to the Health Assembly;

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

ACCEPTS the Director-General's financial report and audited financial statements for the financial period 1 January 1980 - 31 December 1981 and the reports of the External Auditor to the Health Assembly.


2 Document A35/10.
3 Document A35/30.
WHA35.4 Status of collection of assessed contributions and status of advances to the Working Capital Fund

The Thirty-fifth World Health Assembly

1. NOTES the status, as at 6 May 1982, of the collection of assessed contributions and of advances to the Working Capital Fund, as reported by the Director-General;¹

2. CALLS THE ATTENTION of Members to the importance of paying their annual 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 1982;

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.


WHA35.5 Members in arrears in the payment of their contributions to an extent which may invoke Article 7 of the Constitution

The Thirty-fifth World Health Assembly,

Having considered the report of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-fifth World Health Assembly on Members in arrears to an extent which may invoke the provisions of Article 7 of the Constitution;²

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

1. DECIDES not to suspend the voting privileges of Chad and Grenada;

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.


WHA35.6 Assessment of Bhutan

The Thirty-fifth World Health Assembly,

Noting that Bhutan, 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 8 March 1982;

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

¹ Document A35/11.
² Document A35/31.
Recalling the principle established in resolution WHA8.5, and confirmed in resolution WHA24.12, that the latest available United Nations scale of assessments should be used as a basis for determining the scale of assessments to be used by WHO;

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

DECIDES:

(1) that Bhutan shall be assessed at the rate of 0.01% for 1982-1983 and future financial periods;

(2) that the instalment of the 1982-1983 assessment which relates to the year 1982 shall be reduced to one-third of 0.01%.

**WHA35.7 Assessment of Dominica**

The Thirty-fifth World Health Assembly,

Noting that Dominica, 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 13 August 1981;

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

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

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

DECIDES:

(1) that Dominica shall be assessed at the rate of 0.01% for the second year of the financial period 1980-1981 and for future financial periods;

(2) that Dominica's assessment relating to the year 1981 shall be reduced to one-ninth of 0.01%.

WHA35.8 Assessment of Zimbabwe

The Thirty-fifth World Health Assembly,

Recalling that the Thirty-third World Health Assembly, in resolution WHA33.13, fixed a provisional assessment for Zimbabwe at the rate of 0.01%, to be adjusted to the definitive assessment rate when established;

Noting that the United Nations General Assembly, in resolution 36/231, established the assessment of Zimbabwe at the rate of 0.02% for 1980 and future years;

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

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

DECIDES:

(1) that Zimbabwe shall be assessed at the rate of 0.02% for 1980-1981 and future financial periods;

(2) that the instalment of the 1980-1981 assessment which relates to the year 1980 shall be reduced to one-third of 0.02%.


WHA35.9 Review of the Working Capital Fund

The Thirty-fifth World Health Assembly,

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

A

1. DECIDES that:

(1) Part I of the Working Capital Fund, composed of advances assessed on Members and Associate Members, shall be established in the amount of US$ 5 128 670, to which shall be added the assessments of any Members or Associate Members joining the Organization after 15 May 1981, the date of adoption of the scale of assessments for the financial period 1982-1983;

(2) the advances to the Working Capital Fund shall be assessed on the basis of the scale of assessments adopted by the Thirty-fourth World Health Assembly for the financial period 1982-1983, adjusted to the nearest US$ 10;

(3) any additional advances shall be due and payable on 1 January 1983;

(4) any credits due to Members and Associate Members shall be refunded on 1 January 1983 by applying these credits to any contributions outstanding on that date or to the 1983 assessments;

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

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

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

C

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

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

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

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

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

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

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

D

1. REQUESTS Members and Associate Members to make every effort to pay their contributions on the dates on which they are due, in order to preclude the need to increase the amount of the Working Capital Fund;

2. REQUESTS the Director-General to continue his efforts to secure early payment of Members' and Associate Members' assessed contributions;

E

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

RESOLUTIONS AND DECISIONS

WHA35.10 Regulations for expert consultation and institutional collaboration

The Thirty-fifth World Health Assembly,

Having considered the draft new regulations for expert advisory panels and committees submitted to it by the Executive Board;¹

1. APPROVES the new regulations for expert advisory panels and committees in replacement of those adopted by the Fourth World Health Assembly² and amended by the Thirteenth World Health Assembly;³

2. ENDORSES resolution EB69.R21 concerning the regulations for study and scientific groups, collaborating institutions and other mechanisms of collaboration.⁴

Hbk Res., Vol. II (4th ed.), 1.7 (Twelfth plenary meeting, 12 May 1982 - Committee B, second report)

WHA35.11 Future organizational studies by the Executive Board

The Thirty-fifth World Health Assembly,

Recalling resolution WHA10.36;

Having considered the recommendations made by the Executive Board in its report on the assessment of previous organizational studies;⁵

1. ENDORSES the Executive Board’s recommendation that organizational studies should be conducted by the Board only when it considers that such a study is desirable;

2. REQUESTS the Executive Board, when recommending the selection of a subject for a new organizational study, to examine:

   (1) whether the subject proposed is timely and significant;

   (2) whether alternative, more effective, less costly or less time-consuming ways of dealing with it exist;

3. URGES the Executive Board, in carrying out organizational studies, to ensure that regions and countries are involved, as appropriate, in the process of their preparation and in the follow-up to their conclusions.

Hbk Res., Vol. II (4th ed.), 3.2.7 (Twelfth plenary meeting, 12 May 1982 - Committee B, second report)

¹ See document A35/15. The regulations will be printed in WHO Basic Documents.
² Resolution WHA4.14.
³ Resolution WHA13.49.
The Thirty-fifth World Health Assembly,

Having considered resolution EB69.R24 and the report of the Director-General\(^1\) on the status of projects financed from the Real Estate Fund and the estimated requirements of the Fund for the period 1 June 1982 to 31 May 1983;

Having also considered the report of the Ad Hoc Committee of the Executive Board on the problems resulting from the water seepage between the eighth and seventh floors of the main headquarters building;\(^2\)

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

1. AUTHORIZES the financing from the Real Estate Fund of the projects summarized in section 14 of the Director-General's report\(^1\) and of the cost of restoring the structural safety of the eighth floor of the main headquarters building, and the reinstallation of the kitchen and restaurant on the eighth floor, at the following estimated costs:

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost (US$)</th>
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<tbody>
<tr>
<td>Contribution towards the construction of a building for the Caribbean Food and Nutrition Institute, subject to the conditions stated in operative paragraph 1 (1) of resolution EB69.R24</td>
<td>300,000</td>
</tr>
<tr>
<td>Additional stand-by generator for the Regional Office for South-East Asia.</td>
<td>250,000</td>
</tr>
<tr>
<td>Repairs and alterations to the Regional Office for Europe.</td>
<td>303,000</td>
</tr>
<tr>
<td>Restoration of the structural safety of the eighth floor of the main headquarters building, reinstallation of the kitchen and restaurant, and arrangements for temporary catering facilities during the period required for all the work involved</td>
<td>2,606,000</td>
</tr>
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2. APPROPRIATES to the Real Estate Fund, from casual income, the sum of US$ 3,409,000.

Hbk Res., Vol. II (4th ed.), 6.1.7; 6.3.2 (Twelfth plenary meeting, 12 May 1982 - Committee B, second report)

The Thirty-fifth World Health Assembly,

Having considered the report\(^3\) of the Director-General;

Believing that at this juncture of the Organization's life, when all Member States are striving towards attaining the social goal of health for all by the year 2000, they should benefit to the maximum extent possible from the partnership with their Organization in this endeavour;

1. REQUESTS the Director-General and the Government of Egypt to continue, in compliance with resolutions WHA34.11 and EB69.R15, their consultations in accordance with the whole of paragraph 51 of the Advisory Opinion of the International Court of Justice of 20 December 1980;

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\(^1\) Document EB69/1982/REC/1, Annex 11.

\(^2\) See Annex 1.

\(^3\) See Annex 2.
2. REQUESTS the Director-General to prepare and submit to the Thirty-sixth World Health Assembly a comprehensive study on all the implications and consequences of relocating the Regional Office for the Eastern Mediterranean from its present site in Alexandria to another site in the Region, including, inter alia, a description of the advantages and disadvantages of any such decision, and of all related financial, legal, technical and institutional implications for WHO and its Member States;

3. EXPRESSES its appreciation to the Director-General for the measures so far taken to ensure as far as possible the effective implementation of health programmes in the Region;

4. REQUESTS further the Director-General to continue to take whatever action he considers necessary to ensure the smooth operation of the technical, administrative and managerial programmes of the Region, including the setting-up of any operational facilities he deems necessary, in order to enable all Members of the Region to benefit fully from their Organization until the Health Assembly has made a decision on the study referred to in operative paragraph 2.

Hbk Res., Vol. II (4th ed.), 4.2.5

(Twelfth plenary meeting, 12 May 1982 - Committee B, second report)

WHA35.14 Policy on patents

The Thirty-fifth World Health Assembly,

Recognizing the need for affirmative action to make health care resources available to all, and the role of incentives in the development of health technology that is not at present available;

Convinced that, in contributing to the development of health technology, WHO should seek to ensure its wide availability to Member States at appropriate cost;

Recognizing that, when desirable, close contacts with respect to policy on patents should be maintained between WHO and other organizations of the United Nations system;

1. DECIDES that it shall be the policy of WHO to obtain patents, inventors' certificates or interests in patents on patentable health technology developed through projects supported by WHO, where such rights and interests are necessary to ensure development of the new technology; the Organization shall use its patent rights, and any financial or other benefits associated therewith, to promote the development, production, and wide availability of health technology in the public interest;

2. REQUESTS the Director-General to report to the seventy-first session of the Executive Board, the Thirty-sixth World Health Assembly, and periodically thereafter, on the progress and the methods of implementation of this policy and on any problems pertaining thereto, as well as on consultations with the international organizations concerned.

Hbk Res., Vol. II (4th ed.), 1.6

(Twelfth plenary meeting, 12 May 1982 - Committee A, second report)

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1 See Annex 3.
The Thirty-fifth 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, social, psychological, mental and physical conditions of the population under occupation, and that this can be rectified only by the complete and immediate termination of the occupation;

Considering that the States parties to the Geneva Convention of 12 August 1949 pledged, 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;


Taking note of the report \(^1\) of the Special Committee of Experts, especially paragraph 3.7 stressing that international cooperation to promote health should be more dynamic in the occupied territories and that involvement of international institutions and organizations, including WHO, is necessary;

Observing with great concern the increasing violence and oppression practised against the civilians in the occupied Arab territories, including Palestine and the Golan, which have resulted in the isolation of cities and villages under strike and in depriving them of basic necessities of life such as water and medicaments, and which have caused:

(1) the paralysis of all institutions, including municipalities and medical, social and educational establishments;

(2) killing and injuring of a great number of civilians by the military authorities and the armed settlers;

(3) precluding the population in the occupied territories from practising their religious rites, as occurred in the attack on the Aqsa Mosque and the Church of the Holy Sepulchre and the arrest of religious personalities;

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\(^1\) Document A35/16.
1. CALLS upon the occupying authorities to desist from all continued acts of violence and oppression and to reinstate the dismissed mayors in their offices so that they may perform their duties in the public health and social spheres;

2. CONDEMNS Israel for its annexation of Jerusalem and the Golan and considers this procedure null and void and with no legal validity; condemns, too, all the procedures aimed at the annexation of other occupied Arab territories;

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

4. 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 the Golan, 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;

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

6. 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;

7. 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;

8. 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;

9. CONDEMNS Israel for continuing its aggressive policy, its arbitrary practices and its continuous shelling of residential areas in Lebanon, which have caused death, injury and mutilation to hundreds of civilians;

10. ENDORSES the opinion of the Special Committee of Experts, expressed in paragraphs 4 and 8 of its report, A34/17, that the "socioeconomic situation of a population and its state of health are closely related" 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;

11. CONDEMNS Israel for not allowing the Special Committee to carry out its tasks fully according to World Health Assembly resolution WHA33.18;

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

Having examined the annual report of the United Nations Relief and Works Agency for Palestine Refugees in the Near East;
Deeply concerned at the deterioration of the Agency's situation with regard to its budget and the services provided owing to the repeated Israeli aggression;

1. REQUESTS States to increase their contributions so that the Agency can 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

REQUESTS the Director-General:

(1) to increase collaboration and coordination with the Palestine Liberation Organization concerning the provision of the necessary assistance to the Palestinian people;

(2) to establish three health centres in the occupied Arab territories, including Palestine, provided that the centres shall be under the direct supervision of WHO.


WHA35.16 Emergency health and medical assistance to Democratic Yemen

The Thirty-fifth World Health Assembly,

Noting with grave concern the serious flooding that recently occurred in Democratic Yemen;

Aware of the health and medical assistance urgently required by the Government of Democratic Yemen to cope with the situation resulting from the floods;

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

2. REQUESTS the Director-General:

(1) to provide forthwith emergency health and medical assistance to the Government of Democratic Yemen and allocate the necessary funds for this purpose as soon as possible;

(2) to consult with the Government of Democratic Yemen in order to establish a health and medical assistance programme to forestall the consequences of the floods for the next five years;

3. CALLS upon specialized agencies and other United Nations bodies 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 (Thirteenth plenary meeting, 14 May 1982 - Committee B, third report)
WHA35.17 Health implications of development schemes

The Thirty-fifth World Health Assembly,

Recalling resolution WHA17.20 on the importance of paying special attention to the health implications of large-scale socioeconomic development schemes;

Recalling further resolution WHA18.45 on the same issue;

Noting that many development projects carry major potential health hazards and dangers for the environment, and that frequently insufficient resources are made available and/or applied in the planning and implementation of development projects to assess these hazards and to prevent their occurrence;

Noting further that, on occasions in the past, the health of populations and the environment have deteriorated as a result of development projects, especially those involving water resources development;

1. PLEDGES WHO's total commitment to work with Member States, national and international agencies and financial institutions to incorporate the necessary preventive measures into development projects to minimize the risks to the health of populations and the environment;

2. URGES Member States, national and international agencies and financial institutions, in the planning and implementation of development projects, especially those involving water resources development:

   (1) to analyse in detail the possible health hazards and environmental dangers of existing and proposed development projects;

   (2) to incorporate into project plans and their implementation adequate measures to prevent, to the greatest extent possible, the occurrence of health and environmental hazards;

   (3) to make adequate provisions for the implementation of the necessary preventive measures in the financing of the relevant development projects;

3. APPEALS to donor countries and relevant financial institutions to assist developing countries in the implementation of this resolution.


WHA35.18 Health assistance to refugees and displaced persons in Cyprus

The Thirty-fifth 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, WHA33.22 and WHA34.20;

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-sixth World Health Assembly on such assistance.


WHA35.19 Health and medical assistance to Lebanon

The Thirty-fifth World Health Assembly,

Recalling resolutions WHA29.40, WHA30.27, WHA31.26, WHA32.19, WHA33.23 and WHA34.21 on health and medical assistance to Lebanon;

Taking note of United Nations General Assembly resolutions 33/146 of 20 December 1978, 36/135 of 14 December 1979, 35/85 of 5 December 1980 and 36/205 of 17 December 1981 on international assistance for the reconstruction and development of Lebanon, calling on the specialized agencies, organs and other bodies of the United Nations to expand and intensify programmes of assistance within the framework of the needs of Lebanon;

Having examined the Director-General's report on the action taken by WHO, in cooperation with other international bodies, for emergency health and medical assistance to Lebanon in 1981-1982;

Taking note of the health and medical assistance provided by the Organization to Lebanon during 1981-1982;

1. EXPRESSES its appreciation to the Director-General for his continuous efforts to mobilize health and medical assistance for Lebanon;

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 necessitate thereby a continuation and a substantial expansion of programmes of health and medical assistance to Lebanon;

4. REQUESTS the Director-General to continue and to expand substantially the Organization's programmes of health 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-sixth World Health Assembly on the implementation of this resolution.

Hbk Res., Vol. II (4th ed.), 1.2.2.3 (Thirteenth plenary meeting, 14 May 1982 - Committee B, third report)

\(^1\) Document A35/19.
RESOLUTIONS AND DECISIONS

WHA35.20 Liberation struggle in Southern Africa - Assistance to front-line States

The Thirty-fifth World Health Assembly,

Considering that the front-line countries are targets of continued military attacks, which the South African racist regime directs, plans and carries out to destabilize their governments, and which hamper their economic and social development;

Considering also resolution AFR/RC31/R12 of the Regional Committee for Africa and the special programme of health cooperation with the People's Republic of Angola prepared by a health mission of the Regional Committee;

Bearing in mind that these continued attacks and threats force the countries concerned to divert large amounts of financial and technical resources from their national health programmes to defence;

Further considering the support that has been reaffirmed for the front-line countries in many resolutions of the United Nations, the movement of non-aligned countries, the Organization of African Unity, and other international organizations and institutions;

1. RESOLVES that WHO shall:

   (1) take emergency measures to help the front-line countries solve the acute health problems of the Namibian and South African refugees;

   (2) provide countries attacked by South Africa with medical assistance, health personnel, medical teams, pharmaceutical products and financial assistance for their national health programmes and for such special health programmes as are necessary as a consequence of the military operations;

2. CALLS upon the Member States, according to their possibilities, to provide adequate medical assistance to the front-line States (Angola, Botswana, Mozambique, United Republic of Tanzania, Zambia, Zimbabwe) and Lesotho and Swaziland;

3. REQUESTS the Director-General to report to the Thirty-sixth World Health Assembly on the progress made in the implementation of this resolution.

Hbk Res., Vol. II (4th ed.), 1.2.2.2 (Thirteenth plenary meeting, 14 May 1982 - Committee B, third report)

WHA35.21 Liberation struggle in Southern Africa - Assistance to Namibia and national liberation movements in South Africa recognized by the Organization of African Unity

The Thirty-fifth World Health Assembly,

Mindful of the prolonged struggle that the Namibian people, led by the South West Africa People's Organization (SWAPO), their sole legal representative, have waged for their liberation, independence and territorial integrity;

Mindful, too, of the struggle that the South African people are waging to attain their national liberation;

Reiterating the support for this struggle expressed in many resolutions of the United Nations, the Organization of African Unity, the movement of non-aligned countries and other international institutions and organizations that call for the immediate and unconditional withdrawal of South Africa's illegal government from Namibia;
Bearing in mind the decisions taken by the United Nations General Assembly at its special session on Namibia;

Aware of the resolutions adopted by WHO and at ministerial meetings of the non-aligned and other developing countries on assistance for the Southern African people;

Persuaded that these peoples can achieve the goal of health for all by the year 2000 only if the illegal occupation of Namibia is ended and Namibia's and South Africa's rights to self determination are recognized;

1. REAFFIRMS its support for the Namibian and South African peoples' legitimate struggle to attain their national liberation;

2. RENEWS its request to the Director-General to continue collaboration with the United Nations agencies and the international community in order to obtain the necessary support in the health sector for national liberation movements recognized by the Organization of African Unity;

3. URGES the Director-General to accelerate the implementation of the plan of action contained in the report of the International Conference on Apartheid and Health;

4. REQUESTS the Director-General to give a detailed report to the Thirty-sixth World Health Assembly on the progress made in implementing this resolution.

Hbk Res., Vol. II (4th ed.), 1.2.2.2 (Thirteenth plenary meeting, 14 May 1982 - Committee B, third report)

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WHA35.22 Diarrhoeal diseases control programme

The Thirty-fifth World Health Assembly,

Recalling resolution WHA31.44;

Having considered the Director-General's report on the diarrhoeal diseases control programme;

1. NOTES with satisfaction the progress made in the establishment of the diarrhoeal diseases control programme and the development of its activities;

2. ENDORSES the dual action-research approach adopted by the programme as the best means of achieving a reduction in diarrhoeal disease mortality and morbidity;

3. URGES Member States to intensify their diarrhoeal disease control activities as an entry point to primary health care, especially in view of the expected immediate impact on early childhood mortality;

4. EXPRESSES warm appreciation to the United Nations Children's Fund, the United Nations Development Programme, the World Bank, and other international and bilateral agencies, for their continued collaboration in and support to the programme;

5. NOTES with concern the gap that exists between the support requirements of the programme and available resources, and accordingly stresses the need for continued maximum support to enable the programme to carry out its planned activities and achieve its objectives;

6. REQUESTS the Director-General:

(1) to continue to collaborate with Member States in developing and strengthening national control programmes through activities in programme planning, training and evaluation, in conjunction with the targets for the International Drinking Water Supply and Sanitation Decade, and to support biomedical and health services research to meet the needs of such programmes;

(2) to continue to collaborate with the United Nations Children's Fund, the United Nations Development Programme, the World Bank and other agencies in support of the programme and in the provision of safe drinking-water and environmental sanitation to deprived or underserved populations;

(3) to make efforts to attract extrabudgetary resources to meet the support requirements of this programme;

(4) to keep the Executive Board and the Health Assembly informed of the progress made in the implementation of the diarrhoeal diseases control programme.


WHA35.23 Plan of action for implementing the Global Strategy for Health for All by the Year 2000

The Thirty-fifth World Health Assembly,

Recalling resolution WHA34.36 in which, in May 1981, the Executive Board was requested to prepare a plan of action to implement the Global Strategy for Health for All by the Year 2000;

Noting with satisfaction the adoption by the United Nations General Assembly of resolution 36/43 on the Global Strategy for Health for All by the Year 2000, in which it recognized that peace and security are important conditions for the preservation and improvement of the health of all people, that cooperation among nations on vital health issues can contribute substantially to peace, and that the implementation of the Strategy constitutes a valuable contribution to the improvement of overall socioeconomic conditions and thus to the fulfilment of the International Development Strategy for the Third United Nations Development Decade;

1. APPROVES the plan of action for implementing the Global Strategy for Health for All by the Year 2000, as submitted to it by the Executive Board;¹

2. THANKS the Board for its work;

3. CALLS on Member States:

   (1) to fulfil their responsibilities as partners in the solemnly agreed Strategy for Health for All by carrying out in their countries, as well as through intercountry cooperation, the activities devolving on them in the plan of action for implementing the Strategy;

   (2) to enlist the involvement of their people in these activities;

4. URGES the regional committees to carry out their share of the plan of action and to monitor its implementation in the regions;

5. REQUESTS the Director-General:

(1) to ensure that the Secretariat carries out fully its part in the plan of action and that it respects the timetable;

(2) to take the action requested of him by the United Nations General Assembly in resolution 36/43, and in particular to take steps to ensure that all appropriate organizations and institutions of the United Nations system collaborate with WHO in implementing the Strategy;

(3) to monitor the implementation of the plan of action and to keep the regional committees, the Executive Board and the Health Assembly fully informed of progress through the reports of the Regional Directors to the regional committees on the implementation of regional strategies and through his reports to the Board on the implementation of the Global Strategy;

6. REQUESTS the Executive Board to monitor progress in implementing the plan of action through the monitoring and evaluation of the Global Strategy in conformity with resolution WHA34.36 and to report to the Health Assembly on progress made and problems encountered.

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

(Thirteenth plenary meeting, 14 May 1982 - Committee A, third report)

**WHA35.24 Implementing the strategy for health for all**

The Thirty-fifth World Health Assembly,

Noting with satisfaction the decisions taken by groups of Member States - the non-aligned and other developing countries - concerning the implementation of the strategy for health for all;

Stressing the importance of the decisions of the non-aligned and other developing countries expressed in the resolutions on:¹

1. implementation of national strategies for health for all by the year 2000,

2. technical cooperation among countries for the achievement of the goal of health for all by the year 2000,

3. network of institutions for health development,

4. exchange of health experts between developing countries;

1. CONGRATULATES the non-aligned and other developing countries for this expression of political commitment to the goal of health for all;

2. REQUESTS the Director-General to mobilize support for these and other Member countries for the implementation of their strategies for achieving health for all through such efforts as are described in the above resolutions.

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

(Thirteenth plenary meeting, 14 May 1982 - Committee A, third report)

¹ See Annex 4.
The Thirty-fifth World Health Assembly,

Having reviewed, in accordance with Article 28(g) of the Constitution, the draft of the Seventh General Programme of Work covering a specific period (1984-1989 inclusive), submitted by the Executive Board;

Convinced that the Seventh General Programme of Work, the first of three new general programmes of work of WHO to be implemented by the target date of the year 2000, constitutes a satisfactory response of the Organization to the Global Strategy for Health for All by the Year 2000;

Believing that the Programme provides an appropriate framework for the formulation of the Organization's medium-term programmes and programme budgets, and that its content has been sufficiently specified to permit evaluation;

Recognizing the important contribution of the regional committees to the development of the Programme;

1. APPROVES the Seventh General Programme of Work;¹

2. CALLS ON Member States to use it when deciding on their cooperative activities with WHO as well as their intercountry health activities;

3. URGES the regional committees to ensure that regional programmes and programme budgets are prepared on the basis of the Seventh General Programme of Work;

4. REQUESTS the Director-General to ensure that the Seventh General Programme of Work is translated by the beginning of the period concerned into medium-term programmes for implementation through biennial programme budgets, and is properly monitored and evaluated;

5. REQUESTS the Executive Board:

(1) to monitor the implementation of the Programme on a continuing basis;

(2) to review the progress and to evaluate the effectiveness of the Programme in supporting the goals of the Global Strategy for Health for All by the Year 2000;

(3) to ensure in its biennial reviews of programme budget proposals that these properly reflect the Programme;

(4) to carry out in-depth reviews of particular programmes as necessary to ensure that the work of the Organization is proceeding in conformity with the Seventh General Programme of Work.

WHA35.26  International Code of Marketing of Breast-milk Substitutes

The Thirty-fifth World Health Assembly,

Recalling resolution WHA33.32 on infant and young child feeding and resolution WHA34.22 adopting the International Code of Marketing of Breast-milk Substitutes;

Conscious that breast-feeding is the ideal method of infant feeding and should be promoted and protected in all countries;

Concerned that inappropriate infant feeding practices result in greater incidence of infant mortality, malnutrition and disease, especially in conditions of poverty and lack of hygiene;

Recognizing that commercial marketing of breast-milk substitutes for infants has contributed to an increase in artificial feeding;

Recalling that the Thirty-fourth World Health Assembly adopted an international code intended, inter alia, to deal with these marketing practices;

Noting that, while many Member States have taken some measures related to improving infant and young child feeding, few have adopted and adhered to the International Code as a "minimum requirement" and implemented it "in its entirety", as called for in resolution WHA34.22;¹

1. URGES Member States to give renewed attention to the need to adopt national legislation, regulations or other suitable measures to give effect to the International Code;

2. REQUESTS the Director-General:

(1) to design and coordinate a comprehensive programme of action to support Member States in their efforts to implement and monitor the Code and its effectiveness;

(2) to provide support and guidance to Member States as and when requested to ensure that the measures they adopt are consistent with the letter and spirit of the International Code;

(3) to undertake, in collaboration with Member States, prospective surveys, including statistical data of infant and young child feeding practices in the various countries, particularly with regard to the incidence and duration of breast-feeding.


WHA35.27  Action programme on essential drugs

The Thirty-fifth World Health Assembly,

Recalling and reinforcing resolutions WHA31.32 and WHA32.41 which are the bases of the action programme on essential drugs;

Having noted the report prepared by the Executive Board Ad Hoc Committee on Drug Policies on behalf of the Executive Board;²

Realizing the complexity of the pharmaceutical sector and its multisectoral nature, and conscious of the need for an adequate managerial structure and financial support for the dynamic progress of this programme;

¹ See Annex 5.
² See Annex 6.
1. THANKS the Committee for its work;

2. ENDORSES the report, and in particular the main lines of action of the programme over the coming years and the plan of action for 1982-1983, subject to the comments made by the Health Assembly;¹

3. URGES all Member States concerned that have not already done so to develop and implement drug policies and programmes along the lines indicated in the report, in conformity with resolutions WHA31.32 and WHA32.41;

4. URGES all Member States that are in a position to do so to provide technical and financial support to the developing countries for the preparation and implementation of drug policies and programmes along the lines of the report, and thanks those Member States that are already doing so;

5. CONGRATULATES the United Nations Children's Fund on its decision to collaborate fully with WHO in carrying out this programme;

6. INVITES other relevant agencies, programmes and funds of the United Nations system, bilateral agencies, nongovernmental and voluntary organizations and the pharmaceutical industry to collaborate in their respective fields of interest in carrying out this programme;

7. URGES all regional committees to ensure that the programme is vigorously pursued in their region and that to this end regional plans of action are prepared and adequate resources are allocated to the programme in the regional programme budgets;

8. REQUESTS the Executive Board to continue to monitor closely the evolution of the programme and to report thereon in the first instance to the Thirty-seventh World Health Assembly in 1984;

9. REQUESTS the Director-General:

(1) to foster the coordinated implementation of the programme among all partners involved throughout the world and to take all necessary measures to implement the programme in its entirety at national, regional and global levels, as well as to monitor its progress on a continuing basis;

(2) to specify the work plan for 1982-1983 as soon as possible;

(3) to intensify WHO's technical cooperation with Member States that so desire in carrying out national programmes for ensuring essential drugs to all in need and, on the request of countries, in providing the support required from other organizational levels of WHO for the development of national supply systems for essential drugs, including production and control;

(4) to ensure that adequate resources are provided for the implementation of the programme and that, when preparing the programme for the period 1984-1985, the necessary financial support is given to it from all available funds through both WHO's regular budget and the attraction of extrabudgetary funds to the programmes of developing countries;

(5) to ensure the sound management of the programme so that it is carried out efficiently and effectively along the lines indicated in the Ad Hoc Committee's report;

(6) to report regularly to the Executive Board on the measures he has taken, on progress achieved, and on problems encountered.

¹ See document WHA35/1982/REC/3, summary records of the fourth, fifth, sixth, seventh, eighth and eleventh meetings of Committee A.
The Thirty-fifth World Health Assembly,

Recalling resolution WHA32.25 concerning collaboration with the United Nations system on health care of the elderly;

Noting the adoption by the United Nations General Assembly of resolution 36/43 on the Global Strategy for Health for All by the Year 2000, which calls for the involvement of all economic and social development sectors in the solution of health care problems;

Noting further, with satisfaction, the intersectoral collaboration established within the United Nations system in preparation for the World Assembly on Aging, 1982;

Recognizing the role played by the nongovernmental organizations in the preparation of the World Assembly;

1. REQUESTS the Director-General:

(1) to continue to collaborate closely with the United Nations in the field of aging, in a role that goes beyond traditional medical concerns and involves the health sector in the larger context of improving the quality of life for the elderly;

(2) to take steps to maintain international coordinating mechanisms established to prepare for the World Assembly on Aging, in order to facilitate the implementation of the plan of action that will be generated by the World Assembly;

(3) to ensure that the Organization's future activities in social development carried out in cooperation with the United Nations system, especially with the regional economic commissions, take account of the plan of action generated by the World Assembly;

(4) to submit a report to a future Health Assembly on the social, health and other technologies that Member States can employ, in different socioeconomic situations, to improve the social, mental and physical wellbeing of the elderly;

(5) to make use of the managerial process for national health development, including relevant research, to help countries to anticipate changing age structures and to develop programmes and long-term plans that will help to sustain the growing number of the elderly, in independence and dignity, within their own homes;

(6) to ensure that reports to the Health Assembly on the implementation of the Global Strategy for Health for All by the Year 2000 take into account the health status of the elderly;

2. REQUESTS Member States:

(1) to take measures to ensure that health issues in aging are given appropriate attention in national contributions to the World Assembly on Aging;

(2) to maintain national coordination mechanisms established to prepare for the World Assembly in order to facilitate the implementation of the plan of action generated by that Assembly;

(3) to include the elderly within national strategies for health for all by the year 2000, and to make provision for their health care within country health plans that take account of national needs and priorities.

Hbk Res., Vol. II (4th ed.), 1.8.4.3

(Fourteenth plenary meeting, 14 May 1982 - Committee B, fourth report)

1 See document EB69/1982/REC/1, Annex 12.
WHA35.29 Health assistance to refugees in Africa

The Thirty-fifth World Health Assembly,

Taking note of resolutions CM/Res.814 (XXXV) and CM/Res.868 (XXXVII) adopted by the Assembly of the Heads of State and Government of the Organization of African Unity at its seventeenth and eighteenth sessions held at Freetown and Nairobi respectively, and United Nations General Assembly resolutions 35/42 and 36/124 on the International Conference on Assistance to Refugees in Africa;

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

Recalling resolution WHA34.35 on health assistance to refugees in Africa;

Taking note of the report of the Director-General and of the discussion at the sixty-ninth session of the Executive Board on health assistance to refugees in Africa;

Gravely concerned at the growing number of refugees in the African continent, who now constitute over half the refugee population of the world;

Bearing in mind the heavy sacrifices that the countries of asylum are making, despite their limited resources, to alleviate the plight of those refugees;

1. REITERATES the need for WHO to give high priority to providing assistance to refugees in Africa in the area of its competence;

2. APPEALS to Member States and to relevant governmental and nongovernmental organizations to provide necessary assistance to the countries of asylum so as to enable them to strengthen their health capacity and provide the facilities and services essential for the care and wellbeing of the refugees;

3. REQUESTS the Director-General:

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

   (2) to submit a comprehensive report to the seventy-first session of the Executive Board and the Thirty-sixth World Health Assembly on the concrete measures taken by the Organization to implement this resolution.

WHA35.30 Long-term planning of international cooperation in the field of cancer

The Thirty-fifth World Health Assembly,

Noting the Director-General's progress report, prepared in accordance with resolution EB61.R29, on WHO's work in the long-term planning of international cooperation in the field of cancer; 1

Recognizing the continuing growing prevalence of malignant diseases throughout the world and the importance of their health and socioeconomic consequences;

1 See document EB69/1982/REC/1, Annex 8.
Considering that previous mandates from the Health Assembly in respect of WHO's programme in the field of cancer, set out in resolutions WHA26.61, WHA27.63, WHA28.85 and WHA30.41, request the Organization to play an important role in promoting relevant cancer control measures, including coordinated cancer research;

Noting that the intensification of activities at WHO headquarters and in the regions, and the progress made since WHO's cancer programme has been given a new orientation in accordance with the Global Strategy for Health for All, have enabled the Organization to establish more effective cooperation with Member States in developing and implementing national cancer control programmes;

Reaffirming the necessity for further development of international cooperation in the field of cancer;

1. THANKS the Director-General for his report;

2. ENDORSES the recommendations of the Programme Committee of the Executive Board\(^1\) and of the Subcommittee on Cancer of the Advisory Committee on Medical Research;

3. URGES Member States to strengthen the development of cancer control measures or, where they are lacking, to consider initiating them, as an integral part of national health plans, allocating resources so as to reach the largest possible segments of the population;

4. ASKS Member States to consider making voluntary contributions to support WHO's activities in cancer prevention and control, including research;

5. REQUESTS the regional committees to review activities for the control of cancer in their regions in the light of WHO's reoriented cancer programme;

6. REQUESTS the Director-General:

\((1)\) to ensure that WHO's reoriented cancer control programme is vigorously pursued, making optimal use of all available resources, and that it is properly monitored and evaluated;

\((2)\) to continue to promote coordinated action for cancer prevention, control and research, inter alia by strengthening the work of the Director-General's Coordinating Committee on Cancer through outside expertise, especially in the field of health services research;

\((3)\) to promote, within the programme of the Organization, the further coordinated development and implementation of the long-term programme of international cooperation in the field of cancer, emphasizing optimal integration with other related activities of the Organization and collaboration with other intergovernmental and nongovernmental organizations concerned;

\((4)\) to report to the Thirty-seventh World Health Assembly on progress in implementing this resolution in the Organization's work.

\(^1\) See document EB69/1982/REC/1, Annex 8.
WHA35.31  Expanded Programme on Immunization

The Thirty-fifth World Health Assembly,

Noting the report of the Director-General\(^1\) on the Expanded Programme on Immunization and the Executive Board's discussion on the report;

Noting further the five-point action programme contained in the Director-General's report, calling for the promotion of the Expanded Programme on Immunization within the context of primary health care, the investment of adequate human and financial resources in the Expanded Programme, the continuous evaluation and adaptation of immunization programmes, and the pursuit of appropriate research;

1. RECOGNIZES that the goal of the Expanded Programme on Immunization, to provide immunization for all children of the world by 1990, is an essential element of WHO's strategy to attain health for all by the year 2000;

2. WARNS that progress will have to be accelerated if this goal is to be met;

3. URGES Member States to take action on the five-point programme annexed to this resolution;

4. EXPRESSES warm appreciation to national agencies and individuals, the United Nations Children's Fund, the United Nations Development Programme, the World Bank and other international organizations whose collaboration has contributed so much to the success of the programme so far;

5. URGES Member States and international organizations that are in a position to do so to commit long-term support to countries unable fully to underwrite the costs involved in complete immunization of their infant populations;

6. URGES Member States to collaborate, especially through technical cooperation among developing countries, in all programme aspects in order to accelerate the achievement of the objectives of the Expanded Programme and in the continuous evaluation of the progress of the programme through appropriate information support;

7. REQUESTS the Director-General:

   (1) to intensify collaboration with Member States to increase the effectiveness of national immunization programmes;

   (2) to promote dissemination of the results of significant research findings and programme developments;

   (3) to continue to keep the Health Assembly informed of the progress of the programme as required.

\(^1\) See Annex 7.
Annex

Five-point action programme

(1) Promote the Expanded Programme on Immunization (EPI) within the context of primary health care:

- develop mechanisms to enable the community to participate as an active partner in programme planning, implementation and evaluation, providing the technical and logistical resources to support these functions; and

- deliver immunization services with other health services, particularly those directed towards mothers and children, so that they are mutually supportive.

(2) Invest adequate human resources in EPI: Lack of these resources in general and lack of management skills in particular represent the programme's most severe constraints. Capable senior and middle-level managers must be designated and given authority and responsibility to carry out their tasks. They require training, not only to be effective with respect to EPI, but also to contribute to the understanding and strengthening of the primary health care approach. Reasons for low motivation and performance in the areas of field supervision and management need to be identified in order that appropriate measures can be taken to encourage managers to visit, train, motivate and monitor the performance of those for whom they are responsible.

(3) Invest adequate financial resources in EPI: For the programme to expand to reach its targets, current levels of investment in EPI, estimated now at US$ 72 million per year, must be doubled by 1983 and doubled again by 1990 when a total of some US$ 300 million (at 1980 value) will be required annually. Over two-thirds of these amounts must come from within the developing countries themselves, the remaining one-third from the international community.

(4) Ensure that programmes are continuously evaluated and adapted so as to achieve high immunization coverage and maximum reduction in target-disease deaths and cases: Such adaptation depends on the development of adequate information and evaluation systems. By the end of 1985 at the latest, each country should be able to:

- estimate reliably immunization coverage of children by the age of 12 months with vaccines included in the national programme;

- obtain timely and representative reports on the incidence of EPI target diseases included within the national programme; and

- obtain information on the quality of vaccine so that it is known that the vaccines employed for EPI meet WHO requirements and are potent at the time of use.

In addition, countries should promote the use of periodic programme reviews by multidisciplinary teams comprising national and outside staff to ensure that operational problems are identified and that a wide range of experience is reflected in the recommendations which are made.

(5) Pursue research efforts as part of programme operations: The objectives should be to improve the effectiveness of immunization services while reducing their costs and to ensure the adequate supply and quality of vaccines. Specific concerns include the development of approaches for delivering services which engage the full support of the community, the improvement of methods and materials relating to sterilization and the cold chain, the acquisition of additional knowledge concerning the epidemiology of the target diseases, further development of appropriate management information systems, and further improvement in the production and quality control of vaccines which are safe, effective and stable.
DECISIONS

(1) Composition of the Committee on Credentials

The Thirty-fifth World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Member States: Colombia; Czechoslovakia; Ivory Coast; Lesotho; Malta; Netherlands; Pakistan; Philippines; Sri Lanka; Sudan; Trinidad and Tobago; and Zaire.

(First plenary meeting, 3 May 1982)

(2) Composition of the Committee on Nominations

The Thirty-fifth World Health Assembly elected a Committee on Nominations consisting of delegates of the following 24 Member States: Bahrain; Botswana; China; France; Gabon; German Democratic Republic; Guinea-Bissau; Guyana; Honduras; Jordan; Luxembourg; Madagascar; Malaysia; Maldives; Nepal; Nigeria; Peru; Qatar; Swaziland; Union of Soviet Socialist Republics; United Kingdom of Great Britain and Northern Ireland; United States of America; Uruguay; and Yemen.

(First plenary meeting, 3 May 1982)

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

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

President: Mr M. Diop (Senegal)

Vice-Presidents:

Dr M. Calles (Mexico), Dr N. Jogeizai (Pakistan), Professor L. von Manger-Koenig (Federal Republic of Germany), Dr C. Nyamdorj (Mongolia), Dr A. Tarutia (Papua New Guinea)

(Second plenary meeting, 4 May 1982)

(4) Election of officers of the main committees

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

COMMITTEE A: Chairman, Professor A. M. Fadl (Sudan)

COMMITTEE B: Chairman, Mr N. N. Vohra (India)

(Second plenary meeting, 4 May 1982)
The main committees subsequently elected the following officers:

COMMITTEE A: Vice-Chairman, Professor O. Öztürk (Turkey);\(^1\) Rapporteur, Mr M. Mboumba (Gabon)

COMMITTEE B: Vice-Chairmen, Dr J. Franco-Ponce (Peru)\(^2\) and Dr J. Azurfn (Philippines);\(^2\) Rapporteur, Mr R. R. Smit (Netherlands)

(First meetings of Committees A and B, 4 May 1982)

(5) Establishment of the General Committee

The Thirty-fifth 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: Bulgaria; Cape Verde; China; Comoros; France; Honduras; Jordan; Mauritania; Paraguay; Qatar; Sierra Leone; Trinidad and Tobago; Uganda; Union of Soviet Socialist Republics; United Kingdom of Great Britain and Northern Ireland; and United States of America.

(Second plenary meeting, 4 May 1982)

(6) Adoption of the agenda

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

(Third plenary meeting, 4 May 1982)

(7) Verification of credentials

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

Members

Afghanistan; Albania; Algeria; Angola; Argentina; Australia; Austria; Bahrain; Bangladesh; Barbados; Belgium; Benin; Bhutan; 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; Dominica; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Ethiopia; Fiji; Finland; France; Gabon; German Democratic Republic; Germany; Federal Republic of; Ghana; Greece; Guatemala; Guinea; Guinea-Bissau; Honduras; Hungary; Iceland; India; Indonesia; Iran; Iraq; Ireland; Israel; Italy; Ivory Coast; Jamaica; Japan; Jordan; Kenya; Kuwait; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Mauritania; Mauritius; Mexico; Monaco; Mongolia; Morocco; Mozambique; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Romania; Rwanda; Samoa;

\(^1\) Professor M. Abdelmoumene (Algeria), the other Vice-Chairman nominated by the Committee on Nominations, was obliged to return to his country, and was therefore not available for this function.

\(^2\) Dr Franco-Ponce and Dr Azurfn being obliged to return to their countries, Dr J. Rodriguez-Diaz (Venezuela) was elected Vice-Chairman in their stead at the Committee’s fourth meeting.
RESOLUTIONS AND DECISIONS

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.

(Fourth and twelfth plenary meetings, 5 and 12 May 1982)


The Thirty-fifth World Health Assembly, after reviewing the Director-General's report on the work of the Organization in 1980-1981, noted with satisfaction the manner in which the Organization's programme for this biennium had been planned and implemented.

(Ninth plenary meeting, 7 May 1982)

(9) Study of the Organization's structures in the light of its functions: implementation of resolution WHA33.17

The Thirty-fifth World Health Assembly took note of the progress report by the Director-General on the study of the Organization's structures in the light of its functions: implementation of resolution WHA33.17.

(Eleventh plenary meeting, 11 May 1982)

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

The Thirty-fifth World Health Assembly, after considering the recommendations of the General Committee, elected the following as Members entitled to designate a person to serve on the Executive Board: Chile; China; France; Iraq; Malaysia; Morocco; Pakistan; Trinidad and Tobago; Union of Soviet Socialist Republics; and Zimbabwe.

(Twelfth plenary meeting, 12 May 1982)

(11) Real Estate Fund and headquarters accommodation

The Thirty-fifth World Health Assembly appointed Mr K. Al-Sakkaf, Dr E. P. F. Braga and Dr R. J. H. Kruisinga as members of an ad hoc building committee to advise the Director-General and the architect, as required, on any matters that may arise during the implementation of the project related to the problems created by water seepage.

(Twelfth plenary meeting, 12 May 1982)

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2 See Annex 8.

3 For report of the General Committee, see document WHA35/1982/REC/2.
(12) Recruitment of international staff in WHO: annual report

The Thirty-fifth World Health Assembly took note of the report by the Director-General on the recruitment of international staff in WHO.1

(Twelfth plenary meeting, 12 May 1982)

(13) Annual report of the United Nations Joint Staff Pension Board for 1980

The Thirty-fifth 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 1980 and as reported by the Director-General.2

(Fourteenth plenary meeting, 14 May 1982)

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

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

(Fourteenth plenary meeting, 14 May 1982)

(15) Reports of the Executive Board on its sixty-eighth and sixty-ninth sessions

The Thirty-fifth World Health Assembly, after reviewing the Executive Board's reports on its sixty-eighth3 and sixty-ninth4 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, 14 May 1982)

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

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

(Fourteenth plenary meeting, 14 May 1982)

1 Document EB69/1982/REC/1, Annex 16.
2 Document A35/21.
5 See also document A35/2.
ANNEXES
ANNEX 1

REAL ESTATE FUND AND HEADQUARTERS ACCOMMODATION

EXAMINATION OF PROBLEMS RESULTING FROM THE WATER SEEPAGE BETWEEN THE EIGHTH AND SEVENTH FLOORS OF THE MAIN HEADQUARTERS BUILDING

1. Report of the Ad Hoc Committee of the Executive Board

In January 1982 the Director-General reported to the Executive Board on the problems created by water seepage from the kitchen of the restaurant on the eighth floor of the main headquarters building and the results of the examination of the seepage by a firm of consulting engineers specializing in the detection and treatment of defects in reinforced concrete.

At the conclusion of its consideration of this matter, the Board decided, by resolution EB69/R24, to establish an ad hoc committee "to examine the problems resulting from the water seepage between the eighth and the seventh floors of the main headquarters building and to submit its recommendations directly to the Thirty-fifth World Health Assembly".

The report of the Ad Hoc Committee, with supporting documents, is submitted herewith for consideration by the Health Assembly.

1. The Ad Hoc Committee of the Executive Board, consisting of Mr K. Al-Sakkaf, Dr E. P. F. Braga and Dr R. J. H. Kruisinga, met on 31 March and 1 April 1982 at WHO headquarters. The meeting was also attended by representatives of the Director-General, a representative of the consulting engineers, Mr S. E. Thomasen, and the architect, Mr A. Bugna. The Committee elected Dr Kruisinga as Chairman.

2. The Committee had before it the report of the Director-General to the Executive Board (document EB69/34 Add.1), attached hereto as Appendix 1, and the provisional summary record of the Board's discussions on the subject. It examined in detail a report from the consulting engineers dated 31 December 1981, an architect's report dated 19 March 1982, and a report by the Director-General (attached as Appendix 2) outlining his further consultations with the consulting engineers and the architect, and indicating possible courses of action that he had examined.

3. The Committee inspected the kitchen and the areas where seepage damage had occurred, and carefully examined all sites mentioned in the various options envisaged in the Director-General's report (Appendix 2).

1 See resolution WHA35.12.
2 The final summary record appears in document EB69/1982/REC/2, pp. 282-284.
4. The Committee then considered the report of the consulting engineers, and in particular the basic question as to whether there actually existed an imperative and unavoidable need to take remedial action immediately, despite the important financial implications. The Committee heard a detailed exposé by the consulting engineers, and examined photographs and plans showing the spread of the corrosion damage. The Committee particularly noted the following conclusions in the engineers' report, which it considered essential to include in extenso in its report to the Health Assembly:

The framing system consists of two longitudinal beams, a reinforced concrete slab, and a series of transverse beams which cantilever out from the longitudinal beams. Each of the transverse beams are prestressed with two high-strength steel tendons. The transverse beams are the weakest element in the framing system since they rely entirely on the steel tendons for their strength and will collapse if one of the tendons fails.

The investigation found that the membrane in the kitchen floor slab was installed incorrectly and is incapable of preventing water seepage through the slab. The constant leakage has corroded some of the reinforcing steel bars in both the beams and the slab and has deteriorated the concrete.

The prestressing tendons in both the longitudinal and the transverse beams were placed in the concrete forms inside galvanized steel ducts. The concrete was then poured, the tendons stressed, and finally the steel ducts were filled with cement-grout. The combination of duct and grout was intended to protect the tendons against corrosion and to minimize the effect of breakage of the tendons. During the investigation, holes were drilled into the transverse beams and the tendons were examined. Of the nine ducts opened, one was found to be only partly filled with grout and another duct was completely ungrouted. The tendons in both of these ducts were covered with spots of corrosion.

The type of steel used for the prestressing tendons and the high tensile stress in the steel makes it very vulnerable to corrosion and breakage. The design of the building provides no second line of defence against collapse if the prestressing tendons fail. With a large proportion of ungrouted prestressing ducts, corrosion of the tendons and subsequent failure of the floor framing is a distinct possibility. The consequences of failure in the transverse beams could be severe.

We recommend that the leakage from the kitchen be eliminated as soon as possible either by relocating the food service facilities or by installing a waterproof membrane below the kitchen floor slab. We further recommend that, in order to prevent failure now or in the future, the eighth floor framing be strengthened.

5. In his illustrated oral presentation, the representative of the consulting engineers added that in the mid-1960s, when the headquarters building was constructed, prestressed concrete beams were believed to need no further strengthening. In the meantime it had become evident that additional reinforcing steel was absolutely indispensable, and reinforcing rods were now invariably used. The striking and deliberately bold design of the building, which was one of its attractions, aggravated the risk of collapse in case of corrosion. One or more of the transverse beams could give way at any time, and remedial action was essential.

6. The Committee was convinced that the risk of collapse of the eighth floor was serious and could not under any circumstances be ignored. It therefore agreed with the consulting engineers that "it is of the highest importance that the seepage through the kitchen floor be eliminated and that the structural safety of the eighth floor be restored". In this context, the Committee was informed that, upon the advice of the consulting engineers, and pending the reinforcement of the eighth floor framing, a sensor-operated alarm system would be installed in order to monitor the behaviour of the structural framing so that timely safety measures could be taken in case of need.

7. The Committee therefore examined the various possible courses of action which the Director-General had outlined in his report (Appendix 2). After visiting the premises concerned, it concurred with the Director-General's view that the idea of reinstalling the restaurant on the eighth floor and installing the kitchen facility elsewhere in the building
(Option 2) was not feasible, for the reasons indicated in the report. It also considered that the elimination of catering facilities at headquarters (Option 3) was not acceptable.

8. The Committee was therefore left with only two options, both of which included the demolition of the kitchen area, the control and grouting of the prestressing tendons, and the reinforcement of the beams. These options were: (a) the reinstallation of the kitchen and restaurant on the eighth floor (Option 4); and (b) the construction of a new kitchen and restaurant elsewhere, and the use of the eighth floor for offices and meeting rooms (Option 5).

9. In examining the option of reinstalling the kitchen and restaurant on the eighth floor (Option 4), the Committee took note of the fact that the water-tightness of the kitchen floor could be guaranteed only if part of the seventh floor were to be transformed into a "services and maintenance area" to make it possible to inspect, maintain and repair a drainage system that would be easily accessible. However, this solution would entail the permanent loss of 28 badly needed office modules on the seventh floor as well as the adjoining corridor, representing a building value which was estimated by the architect at approximately Sw.fr. 2 000 000. Moreover, during the whole 13-month period which the architect estimated as being required for the work envisaged, temporary catering arrangements would have to be provided for staff and visitors. While the immediate direct expenditure to be incurred under this option appeared to be less than that under other alternatives, the Committee felt that the permanent loss of considerable office space, the relatively long period of disruption entailed by the required work and the need for temporary catering arrangements during this period could definitely not be ignored in assessing the relative merits of the various options.

10. In examining the possibility of constructing a new kitchen and restaurant together in a location other than the eighth floor of the main headquarters building (Option 5), the Committee considered four possible sites. It could only agree with the Director-General that it was not feasible to install the kitchen and restaurant in the new extension to building L. Regarding the possibility of installing the kitchen and restaurant facility in the area of the headquarters building under the library, it was pointed out to the Committee that this was clearly the most expensive of the courses of action considered, since it would involve additional expenditure for the relocation and reconstruction of the workshops. The Committee also felt that this option would be the least attractive from the aesthetic viewpoint.

11. The Committee therefore considered the possibility of constructing a new building in the WHO grounds to house the kitchen and restaurant facilities. A proposal was presented by the architect, with two alternative sites: a building adjacent to building L, or a building adjacent to the southern extension (the Executive Board block) of the main building. The Committee noted the additional cost of Sw.fr. 620 000 for the second alternative - mainly due to the elevated walkway which would have to be constructed in order to provide access to a building adjacent to the Executive Board block. However, the Committee considered that the site adjacent to building L had significant drawbacks: it is relatively inaccessible from the main building; it is aesthetically less attractive, being surrounded on three sides by taller buildings; and its use for this purpose would make any further use of the site impossible. The site adjacent to the Executive Board block is more accessible and would provide a pleasant view on three sides, and a well designed two-storey building in this area would not be aesthetically unattractive. The Committee considered that the advantages of the latter site outweighed the relatively small difference in cost, and therefore recommended that, if new restaurant and kitchen facilities were to be constructed in a separate building on the WHO grounds, this should be done on the site adjacent to the Executive Board block.

12. The Committee thus reached the conclusion that the only options which merited serious consideration by the Thirty-fifth World Health Assembly were: (a) reinstallation of the kitchen and restaurant on the eighth floor of the main headquarters building; and (b) construction of a new building adjacent to the Executive Board block to house the kitchen and restaurant facilities, and transformation of the eighth floor into offices and meeting rooms. The cost implications of these two options, as estimated by the architect, are shown in Appendix 3. After thorough consideration, the Committee decided to recommend to the Assembly that it approve the construction of a new building adjacent to the Executive Board block to house the kitchen and restaurant facilities, for the following reasons:
(a) A new building for the restaurant and kitchen provides the only absolute guarantee that the seepage and consequent structural damage to the main headquarters building would not recur.

(b) This option would not entail the loss of required essential office space on the seventh floor of the headquarters building, the value of which is estimated at approximately Sw.fr. 2 000 000. Moreover, it would result in the gain of office space on the eighth floor, the value of which is estimated at Sw.fr. 3 200 000. These facts render Option 5 financially more attractive than Option 4.

(c) As the construction of a new building would precede the structural repair work, there would be no need to make interim catering arrangements for the staff and visitors, which would be the case for a period of approximately 13 months under Option 4.

(d) The period during which some offices on the seventh floor would have to be closed and its occupants transferred to other premises because of work to be performed on the seventh floor ceiling would be nine months under Option 5 as compared with 13 months under Option 4. The longer period of closure of the offices on the seventh floor would mean an increase by four months of the time during which the work of the staff would be disrupted. The financial implications of this prolonged disruption are, however, difficult to assess.

13. The Committee also recommended that Mr A. Bugna be appointed as the architect for the project. It will be recalled that Mr Bugna was selected in 1972, at the time of the study of the permanent extension to the headquarters building, by a selection committee including inter alia the Chairman of the Ad Hoc Committee of the Executive Board on Headquarters Accommodation and the Director-General. As Mr Bugna has prepared the present preliminary studies and estimates, he appears to the Committee to be well placed to undertake the project rapidly and efficiently.

14. The Committee also noted the consulting engineers' finding that exposure to the elements of the ends of the longitudinal beams is causing corrosion which could damage the anchorage points of the prestressed tendons reinforcing these beams. Swift action to repair the damage and protect the beams from further deterioration is essential. The Secretariat intends to carry out these repairs as part of its normal building maintenance activities, and no additional funds will be required for this purpose.

Appendix 1
REAL ESTATE FUND AND HEADQUARTERS ACCOMMODATION
Report by the Director-General to the Executive Board

Background

1. The main headquarters building was constructed during the period 1962 to 1966 and was first occupied in the spring of 1966. From the early stages of occupation of the building, there has been water seepage from the kitchen of the restaurant on the eighth floor to the seventh floor. This has been a source of constant preoccupation to the Secretariat since that time. Steps were taken to alleviate the inconvenience caused by the leaking water and, at the same time, studies were undertaken to find ways to permanently stop the seepage.

2. In order to cope with the immediate problem of the inconvenience which the leakage was causing, water collecting pans were installed under the floor of the kitchen in order to catch and evacuate the seeping water, which was damaging the ceiling and dripping into the offices of the seventh floor. Since that time, further water collecting pans have been installed as and when required and this procedure has limited the inconvenience.
3. Various other steps were taken progressively in an attempt to stem the leakage. For example, special mastic was applied around the joints where the kitchen equipment was sunk into the floor and along the joints where the walls meet the floor. Likewise, the underfloor water pipes in the kitchen area were replaced with pipes laid above the surface of the floor.

4. When first discovered, the leakage was immediately brought to the attention of the architectural firm responsible for designing and supervising the construction of the main headquarters building, "Feu Jean Tschumi et Pierre Bonnard", with the request that steps be taken to remedy the situation.

5. The architect, after examination of the kitchen area, proposed that steps be taken to reduce the amount of water on the floor of the kitchen by better control of kitchen operations and the application of sealing compounds on the various joints around the equipment and the walls. The architect later informed the Secretariat that the building plans had not included waterproofing beneath the mortar used for fixing the tiles to the floor of the kitchen.

6. In the quest to stop the water seepage permanently, the Secretariat consulted various engineering firms early in 1968. All of the proposals received implied the demolition of the kitchen floor and an extended period of closure of the kitchen facilities whilst waterproofing work was undertaken.

7. In 1971 plans were being mooted concerning the construction of a permanent extension to the headquarters building. Included in these plans was the proposal to transfer the restaurant and kitchen premises from the eighth floor to the ground floor of the proposed extension. This proposal would have ended the water seepage on the eighth floor and freed for use as additional offices and meeting rooms the space previously occupied by the kitchen and restaurant. However, in May 1973 the Twenty-sixth World Health Assembly decided not to pursue the proposal to construct a permanent extension to the headquarters building (WHA26.46), and thus the idea of transferring the kitchen from the eighth floor had to be abandoned.

8. Water seepage from the kitchen has continued since, but the inconvenience caused to the staff working in the seventh floor offices has been minimized by the use of the water collecting pans.

9. In recent years, according to reports in the specialized engineering press, prestressed concrete structures in various parts of the world have been found to have deteriorated with time due to corrosion, particularly of the metal reinforcing elements within the concrete. In many cases the corrosion of the metal reinforcing elements resulted from incorrect construction procedures, and this led to the collapse of some structures. Because of these reports it was decided that it was necessary to establish whether there was any danger of such structural deterioration in the WHO headquarters building as a result of the water seepage. A contract was awarded to the firm of Wiss, Janney, Elstner and Associates, Inc., consulting and research engineers specializing inter alia in the analysis of water leakage and structural damage to buildings, for a preliminary investigation of any prestressed concrete damage which might have been caused by water leakage at the headquarters building.

Findings

10. In a report dated September 1981, the consulting engineers stated that "the water leakage through the kitchen floor has to be stopped in order to eliminate further damage to the eighth floor framing" and recommended that "the eighth floor framing in the area of leakage below the restaurant kitchen be examined for signs of deterioration and corrosion".

11. Following this report a further contract was entered into with the consulting engineers for a detailed examination of the eighth floor framing for evidence of deterioration and corrosion. The findings of this examination and the ensuing recommendations were included in a report dated 31 December 1981 from the consulting engineers.
12. The consulting engineers found the following:

The membrane in the kitchen floor slab was installed incorrectly and is incapable of preventing water seepage through the slab. The constant leakage has corroded some of the reinforcing steel bars in both the beams and the slab and has deteriorated the concrete.

The prestressing tendons in both the longitudinal and the transverse beams were placed in the concrete forms inside galvanized steel ducts. The concrete was then poured, the tendons stressed, and finally the steel ducts were filled with cement-grout. The combination of duct and grout was intended to protect the tendons against corrosion and to minimize the effect of breakage of the tendons. During the investigation, holes were drilled into the transverse beams and the tendons were examined. Of the nine ducts opened, one was found to be only partly filled with grout and another duct was completely ungrouted. The tendons in both of these ducts were covered with spots of corrosion. The type of steel used for the prestressing tendons and the high tensile stress in the steel makes it very vulnerable to corrosion and breakage. The design of the building provides no second line of defence against collapse if the prestressing tendons fail. With a large proportion of ungrouted prestressing ducts, corrosion of the tendons and subsequent failure of the floor framing is a distinct possibility. The consequences of failure in the transverse beams could be severe.

13. The consulting engineers recommended that "the leakage from the kitchen be eliminated as soon as possible either by relocating the food service facilities or by installing a waterproof membrane below the kitchen floor slab. We further recommend that, in order to prevent failure now or in the future, the eighth floor framing be strengthened".

Conclusion

14. The consulting engineers' report, which was received in January 1982, requires further detailed examination. Hence, it is not possible to submit final proposals to the Board's present session on the future course of action to be taken.

15. In view of the serious implications of the consulting engineers' report, the Director-General proposes to undertake further consultations with them and with an architect with a view to determining the various options which lead from these findings. For this purpose, the Director-General proposes to consult Mr Arthur Bugna, the architect selected in 1972, at the time of the study of the permanent extension to the headquarters building, by a selection committee including inter alia the Chairman of the Ad Hoc Committee of the Executive Board on Headquarters Accommodation and the Director-General.

16. Because of the possible consequences of damage to the structure of the building should the water seepage through the floor of the kitchen be allowed to continue, the Director-General believes that urgent action should be taken to determine the most appropriate steps to remedy the present situation. In addition, should it be necessary to undertake major repair work on the floor of the kitchen and the ceiling of the seventh floor, it would be necessary to relocate the staff working on the seventh floor. It would therefore be desirable to take the opportunity offered by the forthcoming availability in the summer of 1982 of office space in the newly constructed extension to building L in order to accommodate the staff displaced by the repair work before the space in the new extension is permanently occupied.

17. Thus, in order to tackle this matter with the least possible delay, the Director-General suggests that the Executive Board may wish to establish a small ad hoc committee, possibly composed of no more than three members, to which he would report on the further consultations with the consulting engineers and the architect and make proposals on the course of action to be pursued. The committee would study these proposals and submit its conclusions and recommendations directly to the Thirty-fifth World Health Assembly in May 1982.
EXAMINATION OF THE PROBLEMS RESULTING FROM THE WATER SEEPAGE BETWEEN THE EIGHTH AND SEVENTH FLOORS OF THE MAIN HEADQUARTERS BUILDING

Report by the Director-General to the Ad Hoc Committee

25 March 1982

Introduction

1. In document EB69/34 Add.1 (see Appendix 1) the Director-General reported to the Executive Board on the problems created by water seepage from the kitchen of the restaurant on the eighth floor of the main headquarters building and the results of the examination of the seepage by a firm of consulting engineers specializing in the detection and treatment of defects in reinforced concrete.

2. The summary of the Board's discussion on the subject as it appears in the provisional summary record EB69/SR/22 is attached hereto as an Annex. At the conclusion of its consideration of this matter, the Board decided, by resolution EB69.R24, to establish an ad hoc committee "consisting of Mr. K. Al-Sakkaf, Dr. E. F. F. Braga and Dr. R. J. H. Kruisinga to examine the problems resulting from the water seepage between the eighth and the seventh floors of the main headquarters building and to submit its recommendations directly to the Thirty-fifth World Health Assembly".

3. The present report is designed to assist the Committee in reaching conclusions and recommendations to be submitted to the World Health Assembly.

4. In pursuance of paragraph 15 of document EB69/34 Add.1 the Director-General has had further consultations with the consulting engineers and the architect with a view to determining the various options which lead from the recommendation of the engineers to the effect that "the leakage from the kitchen be eliminated as soon as possible either by relocating the food service facilities or by installing a waterproof membrane below the kitchen floor slab" and that "in order to prevent failure now or in the future, the eighth floor framing be strengthened". In the light of this recommendation and of the findings of the consulting engineers which are quoted in paragraph 5 below, the Director-General has examined the following possible courses of action:

Option 1 - Do nothing

5. This option would appear to be ruled out in the face of the findings of the consulting engineers that "the design of the building provides no second line of defence against collapse if the prestressing tendons fail. With a large proportion of ungrouted prestressing ducts, corrosion of the tendons and subsequent failure of the floor framing is a distinct possibility. The consequences of failure in the transverse beams could be severe". Thus, should it be decided to do nothing, the safety of the occupants of the building could be jeopardized, not to speak of other possible consequences of damage to the structure of the building. The Director-General therefore feels compelled to suggest that this option cannot be seriously considered.

6. In view of the recommendation of the consulting engineers to the effect that the eighth floor framing be strengthened in order to prevent failure now or in the future, all of the other

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1 Not reproduced here. The final summary record appears in document EB69/1982/REC/2, pp. 282-284.

2 In examining the prestressed concrete beams under the kitchen floor, the consulting engineers found that the steel tendons had been inserted into the tubes, or ducts, but that the waterproofing substance which should have sealed the steel tendons within the tubes had either been incorrectly applied or had, in many cases, been omitted entirely, thus exposing the steel tendons to corrosion.
options examined would require that the kitchen area be demolished, the prestressing tendons controlled and grouted, and the beams reinforced. Thus, the cost of this work is included in all of the estimates provided by the architect in his report.

Option 2 - Reinstall restaurant on the eighth floor and install the kitchen facilities elsewhere in the building

7. This option would imply that after the work envisaged under paragraph 6 above has been completed the dining areas of the restaurant itself would be maintained on the eighth floor but that the kitchen facilities (the source of the water leakage) would be installed elsewhere. The various areas which have been examined as possible locations for kitchen premises can be considered as "sub-options" of Option 2. The advantage of maintaining the restaurant on the eighth floor is self-evident to anyone who has visited these premises. The space available corresponds to operational requirements and it has been specifically designed for use as a restaurant (ceiling height, ventilation, etc.) at the time of the construction of the building. The view over Geneva, the lake and the Alps is remarkable and the atmosphere is congenial for staff and visitors alike.

Sub-option (a) - Install the kitchen in the first basement (SS1)

8. This sub-option would imply the installation of the kitchen facilities in the area presently occupied by the goods receipt and dispatch service and the office supplies storage and distribution area. These services have been established in their present locations due to the fact that they are immediately adjacent to the service quays with their loading and unloading facilities for service vehicles. The services receive over 800 tons of supplies and equipment every year and dispatch upwards of 200 tons, including vaccines, to country programmes, regional offices and WHO coordinator offices throughout the world. No suitable alternative accommodation could be made available for these essential support services. This sub-option would also imply the blocking of two of the five lifts presently used for passengers and goods for the exclusive use of the restaurant kitchen service. Likewise, the distance of the kitchen from the restaurant itself would result in a deterioration in the quality of the food delivered to the customers. Finally, there would be no daylight available for the kitchen in this area and this would appear to be contrary to the local occupational working codes. For all these reasons, this sub-option would not appear to be a feasible one.

Sub-option (b) - Install the kitchen in the second basement (SS2)

9. This sub-option would imply installing the kitchen facility in the area presently occupied by the current stock of documents and publications for dispatch. The stock is in constant use for daily dispatches and is replenished as required from more static stocks held elsewhere. The displacement of this current stockage area would seriously disrupt the documents distribution service for the Executive Board and the Health Assembly as well as the daily worldwide dispatch services. This sub-option would also imply the same drawbacks as those listed under sub-option (a) in respect of the deterioration in the quality of the food, the blocking of heavily used lifts and the absence of daylight. In addition, there would be a serious problem of transportation of all foodstuffs and other kitchen supplies delivered to the building from the unloading quay on SS1 to the kitchen if the latter is installed on SS2. For these reasons, this sub-option does not appear to be feasible.

Sub-option (c) - Install the kitchen in the workshop area under the library

10. This sub-option would imply the installation of the kitchen facilities in the area presently occupied by the workshops under the library wing of the southern annex of the main building and the consequent movement of the workshops elsewhere. Since the area in question is far removed from the eighth floor and from the lifts, two of which would need to be reserved for the kitchen/restaurant operation as was the case under sub-options (a) and (b), the operation would be even less efficient than under sub-options (a) and (b). Hence this sub-option would not appear to be feasible.
Sub-option (d) - No kitchen

11. This sub-option would imply the use of a central industrial kitchen in the town and the transport of food by vehicle to the WHO headquarters building. The advantage of such an arrangement might be its initial economy in that no reconstruction of kitchen premises would be needed. However, food contracted under such an arrangement would be considerably more expensive for the consumer than that presently prepared on the premises and it would undoubtedly be less palatable. In addition, investigations have revealed that at present no facilities of the size which would be required to provide food for the number of persons who would need to be catered for exist in the Geneva area. Thus, for the reasons outlined, this sub-option would not appear to be feasible.

Option 3 - Cease providing restaurant and cafeteria services at headquarters

12. This option would imply the cessation of all catering facilities at headquarters except for the sale of beverages and cold snacks in vending machines. Up to 700 persons now avail themselves of the restaurant facilities during the luncheon period. Under this option these persons, many of whom are participants in meetings, would have to go elsewhere to eat and, in view of the relative isolation of the WHO headquarters from the city of Geneva, the inconvenience and loss of time would be considerable. Nor would it be possible for the catering facilities of the various organizations located in the vicinity of the headquarters buildings, such as ILO, the Oecumenical Centre, the Red Cross or the United Nations Office in Geneva, to absorb upwards of 700 additional customers a day. In the general context of the operation of headquarters, the elimination of catering facilities does not appear to be advisable.

Option 4 - Reinstall kitchen and restaurant on the eighth floor

13. This option would imply that, after the work envisaged under paragraph 6 of the present report has been completed, a waterproof membrane would be installed below the kitchen floor slab and the kitchen and restaurant would be reinstalled on the eighth floor. The advantages of this option are obvious. The location of the restaurant premises on the top floor of the main building is universally acknowledged as being one of the major attractions of the headquarters complex. Staff and visitors are used to enjoying these facilities not only at lunchtime but also for official receptions. The details of this option are given in the architect's report.

14. This is not only the cheapest option but it would appear that, from the point of view of the Organization, it would also be the most practical and desirable one. The maintenance of a kitchen on the top floor of any building carries with it some risk of water seepage due to the constant use of water in kitchen operations. Hence, the reinforcing work and the waterproofing envisaged in the report of the architect are designed to ensure that the prestressed concrete structure of the building will be protected from corrosion in future. In this respect, however, in his report the architect makes the following statement: "In view of the original design of the structures and the technical problems mentioned in the comments on Option No. 4 and furthermore the impossibility of guaranteeing the absolute water-tightness of the eighth floor slab so that in the not too distant future the same problems might arise as those facing us today (leakage and maintenance difficulties), I advise against reinstalling the kitchens and restaurant on the eighth floor."

15. After consultation with the architect, however, it was agreed that the problem could be overcome by transforming part of the seventh floor (28 office modules and adjoining corridor, i.e. 430 m²) into a "services and maintenance area", which would make it possible to inspect, maintain and repair a drainage system that would be easily accessible. At the same time, the architect pointed out that the building value of the office space which would thus be lost on the seventh floor would be in the order of Sw.fr. 2 000 000.

Option 5 - Construct a new kitchen and restaurant elsewhere, and use the eighth floor for offices and meeting rooms

16. This option would imply carrying out the work indicated in paragraph 6 of the present report and the subsequent transformation of the eighth floor into offices and meeting rooms.
This option would also imply that there would be no need to waterproof the floor of the eighth floor. The architect estimates the cost of the transformation of the eighth floor at approximately Sw.fr. 1 510 000. In addition, this option would imply the construction of a kitchen and restaurant elsewhere in the WHO headquarters grounds. Under this option, three sub-options were considered.

Sub-option (a) - Install the kitchen and restaurant in the new extension to building L

17. This option would imply transforming part of the new extension into a kitchen and restaurant. Since the extension is a prefabricated construction erected on a modular basis to provide 157 individual office rooms and two small meeting rooms, the transformation of this modular construction in order to accommodate kitchen and restaurant facilities is not feasible from an engineering point of view now that the building has been erected. The partitions between the offices are of permanent construction and are all load-bearing. Thus it is not possible to knock down walls which are already erected in order to create the requisite open space for kitchen and restaurant premises. As a consequence, this sub-option is not feasible.

Sub-option (b) - Install the kitchen and restaurant facilities in the area of the workshops under the library and the adjacent area

18. A review of all of the premises comprising headquarters has revealed very few which could be suitably adapted to accommodate a kitchen and restaurant. One of the areas which might appear to offer some of the requisite facilities and accessible adjoining space is that located in the wing underneath the library, an area which currently houses building management workshops. The area is a pleasant one giving a direct access to the grounds and providing a view over the Japanese gardens. This option would imply moving the workshops elsewhere. On the other hand, under this sub-option, the requisite facilities could be constructed before any work is undertaken on the eighth floor as envisaged under paragraph 6 of the present report. Thus there would be no need to make arrangements for temporary catering, as would be the case under options 2 and 4. The report of the architect gives full details concerning this option.

Sub-option (c) - Construct a new building to house the kitchen and restaurant facilities in the WHO grounds

19. A new building to house the kitchen and restaurant could be constructed in the WHO grounds surrounding the present office buildings. The grounds are pleasant and a relatively simple building could provide a suitable cadre for the kitchen and restaurant. This sub-option would not require the displacement of any other services and, as under sub-option (b) above, the requisite facilities could be constructed before any work is undertaken on the eighth floor. The report of the architect gives full details concerning this sub-option, for which he submits two alternatives.

* *

20. In considering all of the options and sub-options described above, the Director-General concluded that for the reasons enumerated it would be useful to give the architect a mandate to study and report on only those which might prove to be feasible. The architect was therefore asked to study and cost the following options:

20.1 Waterproof the kitchen floor area and reinstall the kitchen and restaurant on the eighth floor (Option 4)

The architect's estimate of the length of time required between the start of the work of demolition and the reavailability of the kitchen and restaurant on the eighth floor as well
as the disruption created for the staff on the seventh floor is 13 months. Temporary catering facilities would need to be arranged during this entire period. $Sw \text{fr.}$

- The architect's estimated cost: 4 481 000
- Estimated cost of consulting engineer's fees: 140 000
- Estimated cost of temporary catering facilities: 200 000

Total estimated cost: 4 821 000

20.2 Install the kitchen and restaurant in the workshop area underneath the library (Option 5(b))

The architect's estimate of the time during which the work on the eighth floor will create disruption for the staff on the seventh floor is 9 months. No temporary catering facilities would be required under this option. $Sw \text{fr.}$

- The architect's estimated cost: 8 135 000
- Estimated cost of consulting engineer's fees: 140 000

Total estimated cost: 8 275 000

20.3 Construct a new building for the kitchen and restaurant in the area behind building L and transform the eighth floor into offices and meeting rooms (Option 5(c))

The architect's estimate of the time during which the work on the eighth floor will create disruption for the staff on the seventh floor is 9 months. No temporary catering facilities would be required under this option. $Sw \text{fr.}$

- The architect's estimated cost: 7 305 000
- Estimated cost of consulting engineer's fees: 140 000

Total estimated cost: 7 445 000

20.4 Construct a new building for the kitchen and restaurant in the park south of the Executive Board building and transform the eighth floor into offices and meeting rooms (Option 5(c))

The architect's estimate of the time during which the work on the eighth floor will create disruption for the staff on the seventh floor is 9 months. No temporary catering facilities would be required under this option. $Sw \text{fr.}$

- The architect's estimated cost: 7 925 000
- Estimated cost of consulting engineer's fees: 140 000

Total estimated cost: 8 065 000

21. The reports of the consulting engineer and of the architect have been made available to the members of the Ad Hoc Committee. Likewise the consulting engineer and the architect, as well as the Secretariat, will be available to conduct members on any visit of the premises which may be required and to respond to questions which they may wish to raise before deciding on the recommendations to submit to the World Health Assembly in accordance with operative paragraph 2 of resolution EB69.R24.
Appendix 3
COST IMPLICATIONS OF THE TWO MAIN ALTERNATIVE OPTIONS

The estimates given below include in both cases the unavoidable expenditure for the demolition of the kitchen and the reinforcement of the concrete structure.

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost of construction:</th>
<th>Cost of temporary catering arrangements:</th>
<th>Total expenditure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reinstallation of the restaurant and kitchen on the eighth floor</td>
<td>4 621 000</td>
<td>200 000</td>
<td>4 821 000</td>
</tr>
<tr>
<td>(Option 4 in the report of the Director-General - see Appendix 2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add the architect's estimate of the value of the permanent loss of 430 m² on the seventh floor:</td>
<td></td>
<td></td>
<td>2 000 000</td>
</tr>
<tr>
<td>Duration of closure of some seventh floor offices and temporary catering arrangements: 13 months</td>
<td></td>
<td></td>
<td>6 821 000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost of work:</th>
<th>Cost of rearrangement of eighth floor into offices and meeting rooms:</th>
<th>Total expenditure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction of a new building for kitchen and restaurant in the park south of the Executive Board building (Option 5(c) in the report of the Director-General - see Appendix 2)</td>
<td>6 555 000</td>
<td>1 510 000</td>
<td>8 065 000</td>
</tr>
<tr>
<td>Less the architect's estimate of the value of the space gained by creating new offices and meeting rooms on the eighth floor:</td>
<td></td>
<td></td>
<td>3 200 000</td>
</tr>
<tr>
<td>Duration of closure of some seventh floor offices: 9 months</td>
<td></td>
<td></td>
<td>4 865 000</td>
</tr>
</tbody>
</table>

However, there would be no disruption of catering arrangements; hence, no temporary catering arrangements would be required because the new kitchen and restaurant would be constructed before work would be undertaken on the reinforcement of the eighth floor framing.
2. Report by the Director-General

[A35/26 - 23 April 1987]

1. The Director-General has noted the report of the Ad Hoc Committee of the Executive Board contained in document A35/12\(^1\) and has considered ways in which any action resulting from the Committee's report could be financed.

2. The Director-General first examined the possibility of seeking a loan on favourable terms from the Swiss Government authorities in order to finance the operation. However, in view of the need for prompt action to stem the water seepage from the eighth floor kitchen, the procedures for seeking and securing such a loan would be too time-consuming, since they would involve legislative approval by the Swiss Government. Another possibility would be to obtain a commercial bank loan; this would entail the payment of interest at commercial rates in addition to periodic amortization payments.

3. As in any event a loan would have to be repaid from casual income, the Director-General proposes that the Health Assembly consider financing the project not by obtaining a loan but by appropriating the requisite funds from casual income into the Real Estate Fund.

4. The Director-General further suggests that the Health Assembly might wish to establish an ad hoc building committee, the function of which would be to advise the Director-General and the architect, as required, on any problems that may arise during the implementation of the project. Should the Assembly view this suggestion favourably, it may wish to consider appointing for this purpose the members of the Ad Hoc Committee of the Executive Board - that is, Mr K. Al-Sakkaf, Dr E. P. F. Braga and Dr R. J. H. Kruisinga - who have examined the subject in depth and are now fully acquainted with all aspects of the problems involved.

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\(^1\) Reproduced in part 1 of this Annex.
ANNEX 2
TRANSFER OF THE REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN

1. REPORT BY THE DIRECTOR-GENERAL

[A35/14 - 19 April 1982]

Introduction

To comply with the request contained in operative paragraph 3 of resolution EB69.R15, the Government of Egypt and the Director-General agreed to meet in Cairo during the week starting 15 March 1982. The Government of Egypt was represented by: Ambassador Omran El Shafei, Under Secretary, Ministry of Foreign Affairs; Dr A. G. Khallaf, Under Secretary of State for Development and Research, Ministry of Health; Ambassador Abdel Halim Badawy, International Organizations Department, Ministry of Foreign Affairs; Ambassador Hassan Abdel Hadi, Legal Department, Ministry of Foreign Affairs; and Dr Hassan M. El-Chawaby, Department of Foreign Health Relations, Ministry of Health. The Director-General was represented by the Legal Counsel of the World Health Organization, whom he had designated as his Personal Representative; the Legal Counsel was accompanied by the Director of the Support Programme, WHO Regional Office for the Eastern Mediterranean.

The meeting in March 1982 constituted the continuation of the consultations initiated in November 1981 when the Thirty-fourth World Health Assembly had requested the Government of Egypt and the Director-General to undertake in accordance with the Advisory Opinion of the International Court of Justice. Accordingly, to have a clear picture of the present situation it is necessary to take cognizance successively of the first report prepared by the Director-General dated 16 November 1981 and the summary records of the debates which took place during the Executive Board in January 1982, which led to the adoption by consensus of resolution EB69.R15. It may be observed that the following report does not constitute a chronological record of the consultations. Some of the points mentioned were taken up several times during the meetings and were not necessarily discussed in the order in which they are now presented. For the sake of clarity the notes on the discussions have been regrouped systematically and for each point the report presents the views of the representatives of the Egyptian Government and those expressed by the Personal Representative of the Director-General.

1. General principles and rules applicable to the consultations

At the beginning of the meeting the Personal Representative recalled the general principles and rules applicable to the consultations as set out by the International Court of Justice in its Advisory Opinion. In particular, he stressed that the consultations should be conducted in good faith, and underlined the mutual obligations incumbent upon Egypt and the Organization to cooperate with respect to the implications and effects of a transfer of the Regional Office. He added that, in the event of its being finally decided that the Regional Office should be transferred, their mutual obligations placed a duty upon the Organization and Egypt to effect the transfer in an orderly manner and with the minimum of prejudice to the work of the Organization and the interests of Egypt.

1 See resolution WHA35.13.
2 See resolution WHA34.11.
3 Appended hereto.
2. **Scope of the discussion**

The Personal Representative underlined that in the view of the Director-General, and bearing in mind the wording of the Executive Board's resolution and the debates which took place during the Board's session, these consultations should cover the entire paragraph 51 of the Advisory Opinion of the Court, which contained three subparagraphs - (a), (b) and (c). He recalled that a certain ambiguity had existed in November 1981 and that differing views had been expressed regarding the delimitation of the discussion. In the light of the resolution adopted by the Executive Board, however, it was clear that that ambiguity had now disappeared, since the Government of Egypt and the Director-General were requested "to continue their consultations in accordance with the whole of paragraph 51 of the Advisory Opinion of the International Court of Justice of 20 December 1980".

Acknowledging those statements, the representatives of the Government declared that the mere fact that they were meeting again was evidence of the willingness of the Egyptian Government to continue the consultations and of the keen interest it had in this problem. While reiterating the reservations expressed in November 1981, namely that their undertaking and participation in these further consultations did not in any way prejudice their position of principle against a transfer and their right to present further arguments at a later stage, they stated that they were prepared to explore in depth the various aspects of the present situation. They underlined their understanding of the word "consultation". According to their opinion, consultation required mutual discussion and mutual consideration of the pending problems. If during the first discussions in November 1981 they had considered that they were required only to discuss paragraph 51 (a) of the Advisory Opinion, it was because they had felt constrained to do so; however, they were now prepared to discuss the whole of paragraph 51, not only the conditions and modalities of a transfer but equally all the implications of such a transfer, implications which covered a wide range of complex issues.

The Personal Representative said that he understood well the position of the Egyptian Government in that respect and its wish to discuss the whole of paragraph 51 with all its implications. Nevertheless, he felt obliged to state that although he was ready to discuss the whole of the paragraph he was not prepared to go beyond the limits of the paragraph. Accordingly, the Personal Representative declared that he reserved the right to refuse to discuss any points that he might consider unrelated to paragraph 51 of the Advisory Opinion. He recalled in that respect that, even though the duty to consult imposed upon the parties the obligation to exchange views and to obtain information on the different points involved, it did not necessarily mean reaching an agreement.

3. **Feasibility of a transfer**

The representatives of the Government mentioned several points which, in their view, were related to paragraph 51. They stated that the language used by the Court left the question of the suitability of a transfer of the Regional Office quite open. They declared that this opinion was justified for more than one reason, and in particular because the establishment of the Regional Office had come about after careful scrutiny of the site and the country which later became the host country. The length of negotiations and deliberations both in the host country and at the headquarters of the Organization were viewed as a natural process and had never been considered by any party as a deliberate protraction. They added that since the World Health Assembly was going to face the issue once more at its next session, basing itself on many considerations including the work of the Executive Board and the exercise now being undertaken by themselves and the Personal Representative, they felt that the Assembly should be aware and in full knowledge of all the effects and implications of a possible transfer before taking a decision. In raising those points, they referred to a report which had been prepared by the Director-General in 1979 entitled "Outline of a possible study on the feasibility of relocating WHO headquarters". In that report the Director-General had stated "that the relocation of headquarters from the present host country to any other country would raise a number of very complex issues of a constitutional, legal, political, geographical, financial, logistic and organizational nature". That document

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1 Reproduced in document WHA34/1981/REC/1, Annex 2, part 1. See also p. 54 of this volume.
envisaged four phases: (1) review of the fundamental issues and implications contained in the document, and decision whether, and if so, how to proceed; (2) general in-depth feasibility study, using hypothetical country situations without review of formal proposals from specific countries; and, if found potentially feasible, (3) review of feasibility of specific proposed locations in a number of candidate countries; and (4) consultations and negotiations with a short-list of candidate countries, with the present host country authorities, and the United Nations. The representatives of the Government suggested that a feasibility study be effected taking into account the principles described above in the Director-General's report. They recognized that a study had already been made and was contained in the report of the Working Group of the Executive Board, but from this report they noted that the visits of the Working Group to the candidate countries had been very short, two days in most cases. They also pointed out the fact that the data had been furnished by the governments themselves and that the Working Group had not had a chance to verify or scrutinize these data, which should certainly be updated. With all due respect, they also noted that the Working Group had been composed of health experts who were not familiar with questions of administration, finance or logistics. Finally, they felt that the report established by the Working Group should be considered as a preliminary one and not a real feasibility study, which was now needed. They underlined that the same yardstick should be used for the transfer of the Regional Office as for the headquarters of WHO and that the Organization could not tackle two similar situations with two different approaches. They suggested the formation of a group of experts competent in administration, finance and logistics from headquarters and from the six regions to carry out a further study.

The Personal Representative questioned the applicability to the present situation of the procedure suggested in the document of 1979 for the possible transfer to headquarters. More particularly, the suggestion made by the Government to follow the four steps listed in that document supposed that the two situations were comparable and that the question of transfer was at the same stage in both situations, which in fact was not the case. The outline of a feasibility study for headquarters had been prepared before any formal proposal had been presented for a transfer. In the present situation, on the other hand, the Health Assembly had already requested a study in its decision of 25 May 1979, and by its decision of 28 May 1979 the Executive Board had established a Working Group composed of members from the six WHO regions. The report of the Working Group had then been presented to the Thirty-third World Health Assembly (May 1980), following which resolution WHA33.16 had been adopted. Finally, on 9 May 1980, Sub-Committee A of the second special session of the Regional Committee for the Eastern Mediterranean had adopted a resolution selecting a new site for the Regional Office. With regard to the suggestion to establish a further working group, the Personal Representative added that in all fairness each of the subgroups of the Working Group established to carry out the study had been accompanied by a member of the secretariat competent in administration. He also pointed out that in underlining the need for a feasibility study the Egyptian Government was speaking as one Member State of the Region and not as the host country of the Regional Office, since this question concerned all the Members of the Region. He noted that according to the study made by the Working Group the facilities available at the new site selected would appear to meet the requirements, but in any case the period which would be required to leave the present location in the event of a transfer would normally be sufficient to permit the finalizing of the installation at the new site. The Personal Representative recalled that the Government of the country where the new site was located had acceded to the Convention on the Privileges and Immunities of the Specialized Agencies on 12 December 1950. He added, however, that it had been the practice of WHO and other organizations of the United Nations system to conclude a more detailed agreement with each host country of a regional office. The country selected by the majority of the Members of the Region had indicated its willingness to conclude an agreement with WHO similar to the agreement with the present host country, as stated in the report of the Working Group.

2 Decision WHA32(19).
3 Decision EB64(1).
4 Resolution EM/RC-SSA 2/R.1; see document WHA33/1980/REC/1, p. 67.
4. Cost

In relation to this feasibility study the representatives of the Government raised the matter of the cost. The tables annexed to the report of the Working Group concerning the estimated cost of a transfer should be revised and updated not only regarding the recurring costs but also the non-recurring costs. The question of who would finance those costs also had to be clarified. The representatives of the Government wondered whether the cost would have to be covered by the Members of the Region or by the entire membership of the Organization. They expressed their concern about being assessed, like any other countries in the Organization, to share the cost of a transfer which Egypt believed to be inappropriate. Egypt knew that, in accordance with the terms of the resolution of the Sub-Committee already referred to, the Sub-Committee had decided to "cover through voluntary contributions from the Member States of the Eastern Mediterranean Region the full cost of the transfer of the Regional Office to Amman, and the increased recurring annual costs for a period of five years". They requested, however, some information about what would happen if that pledge was not fully respected as well as what would happen after the five-year period referred to. In that context the Government pointed out that at least one of the countries joining in the original pledge was no longer standing by it.

The Personal Representative answered these questions by providing a table of figures, updated in January 1982, which took into account recurring and non-recurring costs at the present location and at the suggested new location. He explained the change in the figures from 1980 to 1982 and an exchange of views took place on a number of items. He also informed the representatives of the Government that any shortfall in funds would probably have to come from the regular budget of the Organization. The Director-General might however insist on the receipt of the pledges involved prior to embarking on any steps involved in the transfer of the Regional Office in order to avoid that problem.

5. Coordination with the United Nations

The representatives of the Government, referring to the document established by the Working Group, also mentioned the problem of coordination with the United Nations and the need for consultation. They considered that such coordination was necessary more particularly taking into account resolution 32/197 adopted on 20 December 1977 by the United Nations General Assembly and the discussions which had taken place in the Administrative Committee on Coordination in 1949.

The Personal Representative recognized that this consultation was suitable but underlined that strictly speaking the only requirement for consultation with the United Nations mentioned in the Constitution was contained in Article 43 and referred only to the location of the headquarters. The Constitution was silent on the specific point regarding the location of the regional offices. He mentioned nevertheless that in the Agreement signed between the United Nations and WHO, Article XI.2 stated that "Any regional or branch offices which the World Health Organization may establish shall, so far as practicable, be closely associated with such regional or branch offices as the United Nations may establish". In practice, for the establishment of the regional offices consultation had taken place. In certain cases the location of the regional offices had been decided after consultation with the United Nations (the Regional Offices for Africa and for Europe). In some other cases the selection of the site of the office had been decided subject to consultation with the United Nations (the Regional Offices for the Eastern Mediterranean, South-East Asia and the Western Pacific).

6. Agreement between the Government of Egypt and WHO of 25 March 1951

The representatives of the Government raised again the question of the existing Host Agreement. The question whether or not that Agreement would survive would have to be clarified and the question of denunciation of the Agreement should also be considered.

1 See paragraph 22 of the annex to the resolution, quoted in document WHA33/1980/REC/1, p. 51.
2 Economic and Social Council document E/1340, paragraphs 33 and 34.
The Personal Representative recalled that this question had already been considered and he did not think it would be really appropriate to reopen a discussion on the legal nature of the Agreement of 1951, in particular on the question whether it was a real host agreement or an agreement on privileges and immunities only. That question had been discussed at length before the International Court of Justice and the latter had not given any answer. Different views had been expressed regarding the survival or the disappearance of the Agreement in the event of transfer and that situation had not been clarified by the Court. It seemed nevertheless that the problem had no practical effect. In the event of a transfer several agreements already concluded between the Government of Egypt and WHO, or on its behalf, ensured appropriate protection in Egypt for the Organization, its officials and the representatives of its Members. Those agreements were the Convention on the Privileges and Immunities of the Specialized Agencies to which Egypt had acceded on 28 December 1953; the Basic Agreement for Technical Cooperation between Egypt and WHO dated 26 November 1960; and the agreement between Egypt and UNDP signed on behalf of the participating organizations, including WHO, on 10 September 1963 and amended on 30 March 1969. In the view of the Personal Representative it was not really relevant for the future whether or not the 1951 Agreement were retained in the event of a transfer.

Commenting on those observations, the representatives of the Government declared that they had different views on that point, and in any case they maintained that the mere fact that the World Health Assembly took a decision on the transfer of the Regional Office would in itself be a denunciation of the Host Agreement.

7. Constitutional basis of a transfer

The representatives of the Government also raised a point of a constitutional nature, reiterating in particular the position already stated in November 1981 according to which a question of transfer should not arise for reasons other than the health objectives laid down in the Constitution of WHO.

The Personal Representative stressed that the constitutional basis of a transfer had been, without any doubt, fully considered by the International Court of Justice when it had delivered its opinion. In particular, one judge had stated in his separate opinion "that the WHO Assembly lacks competence to terminate the Regional Office's legal status unilaterally for reasons other than the health objectives laid down in the Constitution of the WHO."

The judge in question had regretted that "this fundamental background has been left aside by the Court." It should be noted, however, that in spite of those views the Court had delivered an opinion which did not mention that constitutional problem in the reply to the questions raised, which could be considered significant. Accordingly, the Personal Representative considered that it was difficult for him to speak on a point which had not been clearly addressed by the Court. Neither the Director-General nor his Personal Representative could be a judge of the constitutionality of a measure to be taken by the Health Assembly.

8. Integration of the Sanitary Bureau of Alexandria

The discussions also covered another constitutional question which had already been mentioned in November 1981. This question was related to the nature of the operation which took place in 1948 when the Sanitary Bureau in Alexandria was absorbed by the World Health Organization. The representatives of the Government felt that this phenomenon constituted an "integration" under Article 54 of the Constitution, with the consent of the entire membership of the Sanitary Bureau. Consequently, in their opinion, a transfer should logically also require the unanimous agreement of those that had constituted the Sanitary Bureau at that time.

The Personal Representative recalled that the question of "integration" had been discussed at length not only when the Region had been established in 1948 but also during the debates before the International Court of Justice. The least that could be said was that some

2 Ibid., p. 99.
discrepancies of opinion had existed on that particular point when the Regional Office had been established in 1948 and those differing views had also appeared before the Court. Some judges had considered that there really had been an integration under Article 54 of the Constitution, while some others seriously questioned that position. In fact, the Personal Representative wondered whether that problem could really be considered relevant. Whatever conclusion might be reached on the point, it might be said that a transfer of the Office from its present location to another place would not affect the integration. The mere fact that a pre-existing body was integrated within WHO did not mean that this integration should be reversed if the Office were transferred from one place to another. As one judge had said, "The fact that the pre-existing organization was integrated with the WHO when the Regional Office in Egypt was established does not seem to have any substantial bearing on the interpretation of the 1951 WHO/Egypt Agreement, nor on the determination of any transfer of the Regional Office from the host country".  

The representatives of the Government challenged those views, declaring that they could not accept the fact that the question had no bearing. It was on the basis of the integration that the selection of the site had taken place. It was because a Sanitary Bureau existed and had been integrated within WHO under Article 54 of the Constitution that a regional office had been located in Alexandria by application of Article 44 of the Constitution. In their opinion the physical presence of the Sanitary Bureau in Alexandria had motivated the integration of that office within WHO.

9. Constitutionality of the procedure followed to select the new site

During the discussions, the representatives of the Government questioned the constitutionality of the procedure followed to select the new site. They questioned whether the fact that the majority of the Members of the Region had decided to relocate the Office could be considered by the Health Assembly as being a final decision on the subject. They felt that this constitutional aspect of the problem was open and that the Assembly had still not taken a decision on a transfer.

The Personal Representative drew attention to the wording of Article 44. What was constitutionally required was "the consent of a majority of the Members" situated within the Region and no specific requirement was mentioned by the Constitution regarding the expression of that consent provided that it was expressed by a majority of the Members of the Region. It was, of course, also incumbent upon the Health Assembly to take what final decision it might deem appropriate.

Referring to the previous statement, the representatives of the Government underlined that Article 44(b) of the Constitution was related to the establishment of a regional office. To consider that this constitutional provision automatically applied to the relocation would be a very wide interpretation of the provision. The reason why there was a specific mention of the consent of a majority of the Members for the establishment of a regional office could be very easily explained. The philosophy was that there had to be homogeneity in the Region, a certain identity of problems, whereas for the relocation the same philosophy did not apply.

10. Period of notice

The Personal Representative then took up the point mentioned in subparagraph (c) of paragraph 51 of the Advisory Opinion" relating to the period of notice for the termination of the existing situation regarding the Regional Office at Alexandria. He recalled that in the view of the Court this period of notice should be reasonable in order to permit the transfer from the existing to the new site to be effected in an orderly and equitable manner. He recalled that no fixed period was mentioned by the Court in its Advisory Opinion. Nevertheless, the Court had given some indication as to the possible periods involved by reference to the provisions of host agreements, including the Agreement of 1951 between Egypt and WHO, as well as Article 56 of the Vienna Convention on the Law of Treaties and the corresponding article of the International Law Commission's draft articles on treaties between States and international

1 Ibid., p. 148.
2 See p. 54.
organizations or between international organizations. It should be noted that the period of notice provided for in the host agreements varied from three months, as in the host agreement between Switzerland and the United Nations, to two years, as in the agreement between Switzerland and WHO, or in the agreements concluded between the countries hosting regional offices and WHO, including that concluded in 1951 between Egypt and WHO. In the two other examples mentioned by the Court, i.e., the Vienna Convention and the draft article of the International Law Commission, it was stipulated that "a party shall give not less than twelve months' notice of its intention to denounce a treaty". In the case under consideration the Court had underlined that the paramount consideration for both the Organization and the host State must be to determine a reasonable period of time to enable them to achieve an orderly transfer. In other words, those were the criteria which, in the Court's view, should apply in determining the length of the period of notice, and those indications should be kept in mind when the Health Assembly considered the question, due account also being taken of all the practical arrangements needed, as stated by the Court.

The representatives of the Government stressed that, in fixing a period of notice, one should also keep in mind the fact that the legal aspects were not the only ones to be considered, and that it would be rather difficult to dissociate the legal component from the other elements such as political circumstances. It would not be appropriate to discuss the period of notice purely on a legal basis, and all the different elements should be considered when the determination of the period of notice was discussed by the Health Assembly. The representatives of the Government reiterated that the Court had in two separate subparagraphs - (b) and (c) - of paragraph 51 underlined the necessity of respecting the interests of both parties in an equitable manner. In that respect Egypt, as a Member State, had a direct interest that the work of the Regional Office should not be interrupted or hampered by the transfer. It was for that reason that they had to be very cautious in expressing their views in terms of a period of time which could be reasonable for effecting a transfer. They repeated that it was extremely difficult to consider the period of notice on simple legal grounds while ignoring all the other components of the question.

11. Arrangements needed to effect a transfer

The Personal Representative mentioned also the fact that, in the determination of a reasonable period of notice, due account should be taken of all the arrangements needed to effect the transfer in an orderly manner. Accordingly, he considered that those various arrangements should also be included in the consultations. He mentioned, for instance, the problem related to the denunciation of the lease for the Regional Office building. As indicated in the report of the Working Group, the present lease was due to expire on 1 July 1993. None of the lease agreements signed since 1 July 1949 contained a clause on the denunciation of the lease during its normal duration. However, that question was covered by an exchange of letters between the Regional Director and the Minister of Health of Egypt dated 30 and 31 May 1958 providing that "the Organization may, notwithstanding the provisions of clause 3 of the said Renewal of Lease, at any time either terminate this Renewal of Lease by giving three months' notice in writing to the Government or, subject to the approval of the Government, assign this Renewal of Lease to the United Nations or to any of its specialized agencies of which the Government is a Member". He also recalled that, regarding the leases for staff accommodation, it was mentioned in the report of the Working Group that those leases were mostly negotiated on a year-to-year basis and included a diplomatic clause allowing the tenant to denounce the lease with one to three months' notice if the staff member should be transferred from Alexandria. Regarding the termination of staff contracts, the Personal Representative recalled that a notice period of three months would normally apply in accordance with the pertinent Staff Rules and Regulations of the Organization. Some other questions should also be taken into consideration related to those practical arrangements. It might also be necessary to carry out some repairs to the building, particularly if some installations were to be removed, after which the building would have to be cleaned so that it could be returned in good condition. The contracts related to telex, telephone, electricity, gas, water supply, canteen, etc. would have to be terminated. The Organization would also have to arrange for the disposal of office furniture and equipment which was not to be transferred. The remaining equipment would be packed, moved through customs, and finally transported to the new location. The Organization would make arrangements to maintain, if necessary, some staff to finalize those operations until the normal functioning of the office at the new site had been ensured. Those were some of the arrangements which should be kept in mind when determining a suitable period of notice.
The representatives of the Government, noting that information, underlined that a transfer was a very serious question and should not be decided on hastily. In commenting on the enumeration of administrative and other issues made by the Personal Representative, they stated that the question was more complex than it seemed to be and that the various arrangements were bound to be discussed in a detailed manner only in the event of a final decision to transfer. The Government was therefore not, in all fairness, in a position at the present stage to give its opinion as to a reasonable period of notice, for the reasons already mentioned and because of the difficulty of making a judgement on a purely legal basis.

12. Final observations

At the end of the discussions the representatives of the Government stated that it was essential that the cooperation among the countries of the Region should continue and that every effort should be made to maintain the appropriate functioning of the activities and services of the Organization in the Region. They deplored that the Regional Committee had not met and reiterated Egypt's wish to do everything possible in its efforts to cooperate with the Organization not only as the host country but also as a Member of the Region. They again recalled the reservations expressed at the opening of the consultations, according to which their participation did not in any way prejudice their position as regards any action which might be taken by the World Health Assembly concerning a transfer.

Appendix

REPORT BY THE DIRECTOR-GENERAL TO THE EXECUTIVE BOARD ON THE ACTION TAKEN UNDER OPERATIVE PARAGRAPH 3(1) OF RESOLUTION WHA34.11

INTRODUCTION

It will be recalled that resolution WHA34.11, adopted on 18 May 1981 by the Thirty-fourth World Health Assembly on the question of "Transfer of the Regional Office for the Eastern Mediterranean" requested the Director-General, in its operative paragraph 3(1), to "initiate action as contained in paragraph 51 of the Advisory Opinion and report the results to the sixtieth session of the Executive Board in January 1982 for consideration and recommendation to the Thirty-fifth World Health Assembly in May 1982".

To comply with these requirements the Director-General sent a letter on 12 June 1981 to the Minister of Health of Egypt proposing that a meeting be arranged as soon as possible between representatives of his Government and the Director-General or his Personal Representative. He suggested that this meeting be held either in Geneva or in Cairo. On 9 July the Minister informed the Director-General that his Government was ready to hold the meeting in early November in Cairo. On 7 August the Director-General, acknowledging this letter, proposed that the meeting be convened on 3 November and could continue until 5 November inclusive, or beyond that date if it were felt to be necessary. In the same letter he informed the Egyptian Government that he had designated as his Personal Representative for these discussions the Legal Counsel of the World Health Organization.

The discussions were opened in the offices of the Ministry of Foreign Affairs in Cairo on Tuesday 3 November and continued until the end of the week. The Egyptian Government was represented by: Ambassador Omar El Shafei, Under Secretary, Ministry of Foreign Affairs; Dr A. G. Khallaf, Under Secretary of State for Development and Research, Ministry of Health; Ambassador Abdel Halim Badawy, International Organizations Department, Ministry of Foreign Affairs; Ambassador Hassan Abdel Hadi, Legal Department, Ministry of Foreign Affairs; and Dr. I. Bassouli, Director-General, Department of Foreign Health Relations, Ministry of Health. The Personal Representative of the Director-General was accompanied by the Director of the Support Programme, WHO Regional Office for the Eastern Mediterranean.

The following report submitted by the Director-General delimitates in its first part the area of the discussion; it describes in its second part the content of the discussion; in its third part some final remarks are presented.
1. DELIMITATION OF THE DISCUSSION

1.1 At the beginning of the meeting the Personal Representative of the Director-General recalled the terms of reference of the Director-General as contained in operative paragraph 3(1) of resolution WHA34.11, which refers to paragraph 51 of the Advisory Opinion of the International Court of Justice of 20 December 1980, the pertinent part of which reads as follows:

The Court

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;

Accordingly the Personal Representative of the Director-General pointed out that the consultations required under paragraph 51 related to four points: the conditions, the modalities, the practical arrangements and the period of notice for the transfer of the Regional Office to a new site. The Personal Representative of the Director-General recalled the guidelines underlined by the International Court of Justice in its Advisory Opinion and, more particularly, the basic principle of good faith which had to be applied during this discussion. He also stated that he was prepared to continue the discussion as long as needed, provided it was completed in time to permit the Director-General to present his report to the Executive Board.

1.2 In this respect the Personal Representative of the Director-General formulated the four following questions directly covered by paragraph 51 of the Advisory Opinion:

(1) In the opinion of the Government of Egypt, under what conditions may a transfer be effected?

(2) In the opinion of the Government of Egypt, in accordance with what modalities may a transfer be effected?

(3) What, in the view of the Government of Egypt, would be a minimum reasonable period of notice to be given by WHO?

(4) In the event of its finally being decided that the Regional Office shall be transferred, what, in the view of the Government of Egypt, should be the practical arrangements which would permit the transfer to be effected in an orderly manner and with a minimum of prejudice to the interests of Egypt?

1 Document WHA34/1981/REC/1, p. 58.
1.3 Acknowledging the statement made on behalf of the Director-General, and while underlining the Government's desire to preserve the cooperation existing between Egypt and the Organization, the representatives of the Egyptian Government declared that in accepting the Organization's mission, in accordance with resolution WHA34.11, and in expressing their readiness and willingness to consult in good faith, they would nevertheless like to state that their Government's engagement in these consultations and negotiations did not in any way prejudice its position in the future as regards any action to be taken by the Executive Board and the World Health Assembly. Moreover, they informed the Personal Representative of the Director-General that, in line with the guidance given by the International Court of Justice, the Egyptian Government felt obliged only to discuss the questions mentioned under subparagraph (a) of paragraph 51 of the Advisory Opinion, i.e. the part of this paragraph related to "the question under what conditions and in accordance with what modalities a transfer of the Regional Office from Egypt may be effected". The representatives of the Government underlined that the other question covered by subparagraph (b) of the Advisory Opinion was related to the various arrangements needed to effect the transfer, and in accordance with the wording of this subparagraph (b) this question should be discussed only "in the event of its being finally decided that the Regional Office shall be transferred from Egypt". Considering that there was no decision yet from the Health Assembly as to whether a transfer should be effected, the representatives of the Government stated that the discussion would have to confine itself to the conditions and modalities as stipulated in subparagraph (a). They added that the same reasoning applied in their view to subparagraph (c), which appears after subparagraph (b) and which had to be read in conjunction with it. For practical reasons also subparagraph (c) could not be discussed, since the "period of notice" referred to in this subparagraph (c) would have to be fixed "taking due account of all the practical arrangements needed to effect an orderly and equitable transfer of the Office to its new site", arrangements which were mentioned in the previous subparagraph (b). For all these reasons the Government of Egypt was only prepared to discuss the conditions and modalities in accordance with which a transfer may be effected. Nevertheless, the Government was also prepared to discuss the appropriate measures "to ensure the smooth operations of the technical, administrative and managerial programmes of the Regional Office", referred to in operative paragraph 3(2) of resolution WHA34.11.

1.4 Acknowledging the latter observation, the Personal Representative of the Director-General declared that it was not in the mandate given to him by the Director-General to discuss this type of problem, which was distinct in the terms of resolution WHA34.11 from the present exchange of views within the framework of operative paragraph 3(1) of the resolution, but that he would transmit the wish of the Government to the Director-General. Regarding the other statements made by the Government, the Personal Representative of the Director-General expressed the view that the scope of the discussion should be wider. He recalled that in the resolution the Director-General was expressly requested to initiate action as contained in paragraph 51 as a whole and not only subparagraph (a) of paragraph 51. He also pointed out that there were different possibilities of "initiating" an action; either one could tackle only the first of several steps of an extensive procedure, or one could tackle all the steps without exhausting all the points contained in each step. In particular, the Personal Representative of the Director-General again raised the question of the period of notice. He observed that the discussion of a period of notice was not, in the wording of subparagraph (c), subordinate to the event of its being finally decided that the Regional Office be transferred, as was the case for subparagraph (b), and that there was nothing to compel the conclusion that these two subparagraphs (b) and (c) could only be applied together. He also mentioned the fact that the period of notice could well be said to constitute a fundamental question which would justify consideration within the framework of the present discussion. He repeated that the Director-General was prepared to discuss all the points referred to in paragraph 51, including in particular the question of the period of notice, and it was for this very reason that he had raised this question right from the beginning of the meeting. In the view of the Director-General, it would also have been useful to envisage already now what the practical arrangements should be so as to permit at a later stage a fruitful discussion in good faith in the event of the transfer being finally decided.

1.5 The representatives of the Government of Egypt repeated the willingness of the Government to discuss the conditions and modalities of a transfer and underlined that they did not by any means want to give the Director-General the impression that they were obstructing or avoiding the discussion of additional points, but felt that at this stage the consideration of points other than conditions and modalities would be premature. The Government would be prepared to
face these questions only when a decision of transfer was taken. It considered that it would be neither correct nor proper to speak about the other questions since they were not yet faced with a decision of transfer. Moreover, since the question of practical arrangements determined the period of advance notice, they were equally not in a position to discuss that period at this stage.

2. CONTENT OF THE DISCUSSION

2.1 Within the limitations defined above, the representatives of the Government of Egypt outlined the points which, in their view, should be carefully considered in the event of a decision to transfer the regional office to a new site. For the sake of clarification these points may be summarized as follows:

(i) The Government of Egypt observed that when the countries of a region accepted a certain site for their regional office they were taking a mutual obligation to preserve and maintain this office. The Government declared that accordingly a question of transfer should not arise for reasons other than the health objectives laid down in the Constitution of the World Health Organization.

(ii) The representatives of Egypt also declared that, as a matter of principle, a transfer could be envisaged only for major reasons such as:

(a) technical failure of the Office to carry out its duties;

(b) failure on the part of the host country to meet obligations laid down in the Host Agreement;

(c) global restructuring of the Organization;

(d) unanimous understanding between all Members of the Region that, for technical reasons, a transfer would lead to a better performance of the Office.

(iii) They also stressed the necessity of obtaining from the new host government formal assurances which would safeguard the stability of the Organization and maintain the continued proper performance of its functions. More particularly, the Government of Egypt endorsed the view of the International Court of Justice which at the beginning of paragraph 46 of its Advisory Opinion related to host agreements stated that "in future closer attention might with advantage be given to their drafting".

(iv) The Government of Egypt noted also that in 1980 certain Members of the Region refused to hold a meeting of Sub-Committee A of the Regional Committee in Geneva. Despite the fact that resolution WHA34.11 was adopted by consensus in May 1981 and that the Egyptian Government, which had requested that the meeting be held in Geneva or in another suitable place in the Region, had already designated its delegation, the same situation occurred in 1981. It was clear that this attitude was not related to the venue of the meeting and one might believe that it was not the site of the office which caused difficulties but some other reasons. If other reasons existed then they should be clearly spelled out.

(v) Quoting the report submitted by the Chairman of the Interim Commission in 1948, which said that the conditions in Alexandria were "literally unique", the Government of Egypt underlined that the Organization must carry out an exhaustive study before the selection of a new site, and at least the information provided by the potential host governments themselves should be carefully checked and updated.

(vi) The Government of Egypt declared that the question of cost deserved in-depth consideration and that the Organization should be clear about who was going to meet incurred expenses, more particularly after the five-year period mentioned in operative paragraph 2 of resolution EM/RC-SSA 2/R.1 of Sub-Committee A adopted on 9 May 1980. The Government underlined that it was not prepared to share the expenses incurred by a transfer which, in its view, was unnecessary and wasteful.

2.2 The Government of Egypt took the opportunity of this discussion on conditions and modalities to raise two additional observations.

2.2.1 It questioned the constitutional basis of the transfer and wondered if the situation now being faced was not a problem more related to Article 54 of the Constitution, which concerns the integration of regional organizations such as the Pan American Sanitary Organization and of all other pre-existing intergovernmental regional health organizations, than to Article 44, which deals with the establishment of the regional organizations of WHO, and which for certain delegations was the pertinent provision applicable in the case of transfer. In other words, the Government of Egypt felt that the operation under consideration was not related to the transfer of a regional office to a new site but rather to an operation of ending of the integration provided for in Article 54. Consequently if the relevant article was really Article 54, the consent of the entire membership of the Sanitary Bureau, which, in the view of the Government, was required for the integration within the World Health Organization, should also be required when the inverse operation took place. This matter was, according to the view of the Egyptian Government, not an academic point but constituted an open question which deserved consideration.

2.2.2 The Government also raised the question of the continued existence or survival of the Agreement of 25 March 1951 concluded between WHO and Egypt. What would be the consequences of a transfer on this Agreement? Would the Agreement be maintained at least partially for the activities that the Organization could continue to have in Egypt or would the whole of the Agreement be abrogated upon the removal of the Regional Office? Should the latter be the case, would a similar agreement be negotiated or would no other agreement be envisaged? This problem should be considered at an appropriate stage.

2.2.3 The Personal Representative of the Director-General declared that various possibilities existed; at any rate, whatever solution was adopted, Egypt remained bound by the Convention on the Privileges and Immunities of the Specialized Agencies.

3. FINAL REMARKS

3.1 After the exchange of views on the points raised by the Government of Egypt the Personal Representative of the Director-General summarized the discussions and returned to the question of the limits that the Government had fixed for these discussions. In particular he declared that the interpretation of the Government regarding the term "modalities" appeared too restrictive and did not cover areas which, in the opinion of the Director-General, could have been validly discussed at this stage. He recalled that in accordance with the common definition, as contained in widely used dictionaries, the word "modality" described the manner or way in which a thing is done, a method of procedure, and that, in a legal context, "modality" referred to the mode of procedure or the manner of taking effect. Accordingly, even under paragraph 51(a), one should discuss the way in which the transfer could be done or the manner in which the transfer could take effect.

3.2 The Government of Egypt, acknowledging these observations, stated that it considered that some of the points it had listed in fact covered the problem of modalities, such as the question of a further study or the question of the cost of the transfer.

3.3 Reiterating his position, the Personal Representative of the Director-General stated that the Director-General was prepared to discuss any point related to the questions mentioned under paragraph 51, and could in particular update some of the figures which were mentioned in the report presented to the Executive Board in 1980. He stated that, in view of the obligation to consult in good faith, it would be appropriate to have a discussion also on some other points which could be considered as falling within the category of modalities, such as problems related to the building, the termination of the contracts of the staff and, in particular, the notice period, which in the opinion of the Director-General was a major problem that he was prepared to discuss and that could usefully be considered even at this stage.

3.4 The representatives of the Government stated that they did not equate the principle of good faith with acquiescing to the transfer and that discussing these questions when the conditions for a transfer did not exist would be tantamount to acquiescing to the principle of transfer.
At the end of the discussions, the Personal Representative of the Director-General asked the Government of Egypt if, within the scope of operative paragraph 3(1) of resolution WHA34.11, it had any further observations to make on the points so far discussed or if it wished to raise any additional questions. The representatives of the Government declared that they had no further comments and that the subject could be considered as having been fully covered during the consultation which had taken place; however they reiterated the reservations stated at the beginning of the meeting and added that the position expressed during these discussions did not in any way prejudice the right of Egypt to present further arguments against the transfer at a later stage.

2. COMMUNICATION RECEIVED BY THE DIRECTOR-GENERAL FROM THE DELEGATION OF EGYPT

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

(a) Letter dated 27 April 1982 from the Permanent Representative of Egypt to the Director-General

Dear Mr Director-General,

I have the honour to refer to our conversation on 15 April 1982, regarding the report you intend to submit to the Thirty-fifth World Health Assembly on the consultations you have initiated with the Government of the Arab Republic of Egypt, in accordance with resolutions WHA34.11 and EB69.R15.

I would be grateful if you kindly see to it that the enclosed memorandum be circulated as an official document of the Thirty-fifth World Health Assembly in relation to its agenda item No. 35 entitled "Transfer of the Regional Office for the Eastern Mediterranean", and the above-mentioned report.

With my highest consideration,

(signed) El Sayed Abdel Raouf EL REEDY
Ambassador,
Permanent Representative of Egypt

(b) Text of memorandum

Introduction

I.

The considerations which led to the choice of Alexandria to be the site of EMRO

3. It is pertinent to recall, at the outset, the considerations which originally led to the choice of Alexandria as the site of the Eastern Mediterranean Regional Office.

4. The Alexandria Sanitary Bureau, whose origins date back to 1831, and which was therefore described in one of the most important reference works on international health organizations as "probably the oldest international health body in the world",1 was the first factor that justified the choice of Alexandria as a location for the Regional Office.

5. The existence of the Alexandria Sanitary Bureau, and of other regional bureaus, motivated the drafters of the World Health Organization's Constitution to provide for the possible integration of these bureaus into the new organization and its regional institutions. Thus, Article 54 of the Constitution provided for the integration of these bureaus on the basis of mutual consent of the parties concerned.

6. The first session of the Regional Committee for the Eastern Mediterranean was held at Cairo in February 1949, and was attended by the Director-General of the Organization as well as by representatives of the United Nations and specialized agencies. Both the questions of the choice of the location of the Regional Office and of the integration of the Alexandria Sanitary Bureau were discussed in this session. In this respect, the Committee adopted two resolutions:2 one recommending that the functions of the Alexandria Sanitary Bureau be integrated within the framework of the World Health Organization due to "the long experience and the services rendered by the Sanitary Bureau at Alexandria", the other recommending the selection of Alexandria as the site of the Regional Office for the Eastern Mediterranean. The Committee found it appropriate to include in its resolution the reasons for which Alexandria was chosen, which read as follows:

Resolution on location of the Regional Office

The Regional Committee

Having considered:

(1) the historical role of Alexandria as a centre for epidemiological services to countries in the Eastern Mediterranean Area; (2) the policy laid down in Article XI (2) of the agreement between the United Nations and the World Health Organization which states that: "Any regional or branch offices which the World Health Organization may establish shall, so far as practicable, be closely associated with such regional or branch offices as the United Nations may establish"; (3) the importance of establishing the Regional Office in the proximity of Cairo in which are located or expected to be located offices of the United Nations and specialized agencies as follows: FAO, ICAO, ILO, UNESCO and UN Information Centre; and (4) the desirability of the excellent site and buildings under favourable conditions generously offered by the Government of Egypt,

THEREFORE RESOLVES to recommend to the Director-General and the Executive Board, subject to consultation with the United Nations, the selection of Alexandria as the site of the Regional Office.

7. It was not only the Regional Committee which recommended Alexandria to be the future site of the Regional Bureau. The Interim Commission of the World Health Organization, which assumed the role of the organization in the transitional period between the drafting of the Constitution and the establishment of the Organization, asked its Chairman Dr Stampar to go to Egypt to study the situation of the Alexandria Sanitary Bureau and to examine on the spot the suitability of Alexandria to be the location of EMRO.

Dr Stampar ended his visit by preparing an excellent and comprehensive report, supported with figures and statistics, and based on all the factors and criteria that should be applied in the selection of a location for the Regional Office. It might be useful to read the conclusion of the report submitted by Dr Stampar to the First World Health Assembly, in which he stated:

If we have realized how useful the establishment of a regional organization would be and if we remember what a peculiar situation Alexandria has from the point of view of well-established tradition in precisely this kind of international sanitary work, by reason of its geographical situation and of the present progress of public health in Egypt, we are bound to admit that the conditions which predestinate Alexandria to be the centre of the future regional health organization for the Near and the Middle East are literally unique.¹

8. The above statement clearly shows that the choice of Alexandria as the site of EMRO was due neither to pure chance nor political expediency, but was dictated by practical and historical considerations. This decision was rather the outcome of a comprehensive study to which all the organs of the World Health Organization contributed, and in which there was unanimous agreement that Alexandria was the most suitable location. It also illustrates the close link between the integration of the Alexandria Sanitary Bureau and the establishment of the Regional Office in Alexandria.

9. The wisdom of choosing Alexandria as the site for the Eastern Mediterranean Region has been proven through the three decades since its establishment. Egypt, as a host country, has always lived up to its obligations. Since the establishment of the Office, Alexandria, as a city, has enjoyed ideal socioeconomic conditions, in a climate of peace. The regional activities benefited from cooperation with Alexandria University and with other Egyptian universities and scientific institutions. The principal port in the only country in the Region that is both African and Asian constitutes for the EMRO Office an ideal location. EMRO benefits from the availability of technicians and general service staff, who, in addition to Arabic, are fluent in English and French. All of this is available with the least cost possible in the entire Region.²

II. The transitory nature of the circumstances in which the relocation of EMRO was raised

10. During the Thirty-second World Health Assembly a number of countries raised the issue of the transfer of EMRO to another site in the Region. In making the demand, they praised the host country and the performance of EMRO in Alexandria. The whole case for the transfer was admittedly based on political considerations that existed at the time this demand was made.³ These circumstances are by their very nature transitory. For the relations between Egypt and Arab countries are brotherly relations rooted in the fact that Egypt is a part of the Arab Nation.

11. As we have seen earlier, the choice of Alexandria as the site for EMRO emerged only after thorough study based on objective criteria. This is in contrast to the total absence of any objective argument in favour of relocating EMRO to any other site.

² See document WHA33/1980/Rec/1, Annex 2, part 1(b), which demonstrates that the difference between the current expenses of EMRO in Alexandria and those in any of the other proposed sites can vary by as much as 76%.
ANNEX 2

12. Thus, when the Director-General of the World Health Organization put the following key question "In the opinion of the Government of Egypt, under what conditions may a transfer be effected?", Egypt answered the question by stating:

"A question of transfer should not arise for reasons other than the health objectives laid down in the Constitution of the World Health Organization.

As a matter of principle, a transfer could be envisaged only for major reasons such as:

(a) technical failure of the Office to carry out its duties;
(b) failure on the part of the host country to meet obligations laid down in the Host Agreement;
(c) global restructuring of the Organization;
(d) unanimous understanding between all Members of the Region that, for technical reasons, a transfer would lead to a better performance of the Office."¹

13. It is worth noting that consultations on this point took place in accordance with the Advisory Opinion of the International Court of Justice of 20 December 1980. The point of departure for the World Health Assembly, in assuming its responsibility in this regard, lies in making a judgement on whether transitory political considerations constitute a sound basis for relocating the headquarters of a regional organization. In our view, a decision accepting to transfer a regional office for such considerations would have repercussions which go far beyond the region. It would lend legitimacy to the notion that the site of a regional headquarters is forever hostage to political events in the region in today's tumultuous world. It would open the way for other, future transfers of the EMRO or other regional offices of the World Health Organization for reasons totally unrelated to health, with the disruption in operations which any transfer necessarily entails. It would deprive these offices of the stability which they need to discharge their humanitarian and health functions.

III. The need for a comprehensive study on the advisability and feasibility of a transfer of the Regional Office

14. A decision to transfer the Regional Office from its present site to a new site is obviously of such an importance and complexity that it cannot be taken lightly. It raises a host of financial, managerial and legal problems. It results in considerable expenses in human and material resources. It leads to a disruption in the regional activities. It is therefore appropriate that the Assembly should, in its wisdom, avail itself of a comprehensive study before plunging the Organization into such a course of action. Such a study should be two-fold.

15. In the first place, it should study whether there is an objective need for transferring the Regional Office from its present site to another site, including a comparative study on the advantages or disadvantages of such a transfer. Obviously, there would be no justification to assume the burdens of a transfer unless the proposed site is proved to be more qualified than the present site.

16. A reference has already been made to the elaborate process of selecting Alexandria as the EMRO site. This process included a wide range of factors: the requirement for integrating the old Alexandria Sanitary Bureau in accordance with Article 54 of the Constitution; the various studies undertaken by the Regional Committee and the Chairman of the Interim Commission on the objective criteria which pointed to Alexandria, as a unique choice; the fact that Egypt is a centre of a large number of specialized agencies; etc. It is therefore natural that now, more than 30 years after the establishment of the Office and its successful and efficient performance throughout this period, the World Health Assembly

¹ Report by the Director-General on the first round of consultations with the Government of Egypt, document EB69/28 of 16 November 1981 (appended to part 1 of this Annex), paragraphs 1.2 and 2.1.
must be fully convinced of the advisability of transferring that Office before taking such a decision. On the other hand, there can be no doubt that relocating an office that has been functioning for more than 30 years to another site is a much more complex undertaking than initiating an office in a given site.

17. Second, the comprehensive study should analyse the various problems and implications which are involved in a transfer. The Working Group established by the Executive Board in 1979, to its credit, drew the attention of the World Health Assembly to some of these issues, which were then discussed, among others, in the consultations held between the Government of Egypt and the Director-General in November 1981 and March 1982. Some of the issues concern the relations between Egypt and the Organization and the United Nations system. Others, however, are of direct concern to the World Health Organization as a whole, with consequences for Member States. This is particularly in relation to the financial implications, which would have to be assumed by the Organization, or withdrawn from the budgets allocated to technical health programmes of the Organization. In this respect, there are some questions to which answers should be known in advance: the means of covering the increased recurrent and non-recurrent costs; the financial burdens that Member States would have to assume; the ways of assuring that the Organization itself will be free of any extra financial burdens in the first five years (noting that some of those who have previously undertaken to contribute to the increased costs have subsequently revised their positions); the probabilities of the need of new buildings and accommodation in a possible new site (and by whom these would be financed); etc.

18. Without such a comprehensive feasibility study, which covers these problems, among others, and provides possible solutions to them, we believe that the World Health Assembly would not find it advisable to pronounce itself on the question.

Conclusion

19. It is evident from the above that:

(a) The choice of Alexandria as headquarters for EMRO resulted from comprehensive studies and the application of objective criteria.

(b) Since the establishment of EMRO at its present site in Alexandria it has successfully performed its functions.

(c) The proposal to transfer EMRO to another site is based on transitory political considerations which should not justify EMRO relocation.

(d) A consideration of a decision for relocating EMRO requires a prior study that demonstrates the real and objective need for the proposed transfer. Such a study should also cover the various technical, legal and administrative problems and implications arising from relocation.
ANNEX 3
RELATIONS WITH INDUSTRY AND POLICY ON PATENTS

Report by the Director-General

1. WHAT PATENTS OR INTERESTS IN PATENTS CAN MEAN TO THE OBJECTIVE OF WHO

The overriding objective of the World Health Organization is the attainment by all peoples of the highest possible level of health. The patent systems provided by Member States for the protection of intellectual property can play a useful role in WHO's quest to achieve that goal. WHO can use patents or licences under patents to promote the development, production, and wide availability of health technology.

If research is carried out by or on behalf of WHO, for example to attempt to discover a chemotherapeutic approach for treating a particular disease, and if that research points to a new chemical compound which has some effect against the disease, WHO could, if it obtains patents on that compound, use them to induce a pharmaceutical company to develop a useful drug. For a chemical compound to be developed into a useful drug, extensive (and expensive) studies are required, not only of its efficacy but also of its toxicity, mutagenicity, teratogenicity, etc. A pharmaceutical company would be unlikely to expend its financial, capital, and personnel resources on such development where there was no reasonable likelihood of return on its investment. This likelihood can be increased (although not guaranteed) by ownership by WHO of relevant patents. Thus, where WHO holds the basic patents, it could promote drug development of the new chemical compound to the point at which it can be used in human therapy by providing licences under the patents to a responsible pharmaceutical company which is willing to expend its resources to develop the useful drug.

WHO, by itself holding patents (or sublicensable licences under patents), will be able to ensure the wide availability of that which is patented because it will be WHO, rather than some private or narrow interest, which is in a position to license its Member States, other international organizations, and non-profit entities.

Finally, where WHO has patents on health technology which is developed and ready for production, or sublicensable licences under such patents, it could arrange for the manufacture of the health technology, on its own account or for that of its Member States, by the pharmaceutical or other companies which are willing to provide that health technology under the most favourable conditions.

2. HOW PATENTS AND INTERESTS IN PATENTS CAN BE OBTAINED BY WHO

2.1 How WHO can arrange for ownership of or interests in patent rights in its dealings with research and development partners

Inventions (and the concomitant patent rights) which are made by WHO staff members as part of their official duties are vested ab initio in the Organization. Where inventions are made by researchers working in collaboration with or on behalf of WHO, for example pursuant to a

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1 See resolution WHA35.14.
WHO grant of funds to a university or hospital, the written contract governing the grant can include a provision allocating rights to the invention and its exploitation. It could be provided that ownership remains with the researcher and that WHO is licensed to practise the invention or that WHO itself owns the patent rights. Where relevant patent rights are already the property of a party whose invention WHO wishes to have developed, or where such patent rights arise out of a development process to which WHO's contribution may be essential but is not financially controlling, WHO can serve its objective by obtaining a contract in which the other party agrees to conditions beneficial to WHO Member States, for example an agreement to make available to governments of developing countries a specified number of units of the health care tool developed at a pre-designated favourable price.

2.2 Mechanisms by which WHO may seek patents

Patents are generally national in scope. A patent granted by the government of one country has no effect at all on activities which are carried out entirely in other countries. Since the value of a patent is derived solely from the marketability of the invention which it covers, patent protection is generally sought (only) in those countries in which a significant commercial market is anticipated. Once it is determined that an invention to which WHO has rights has potential commercial significance and therefore is worth patenting, a patent application must be prepared by a team consisting of the actual inventor or inventors and a patent lawyer or agent having a background appropriate to the technology in question. The patent application will then be filed, generally first in a single country and then within a specified period (usually a year) in any other countries for which there appears to be a justification to do so. Recent treaties on patents have tended to simplify filing an application for a patent in more than one country. Under the Patent Cooperation Treaty, which is worldwide in scope, a single patent application is filed and subjected to a preliminary examination. Then, if the applicant still wishes to proceed, a copy of the application along with the examination results is transmitted to each of the countries designated by the applicant for individual decisions on patentability. Under the European Patent Convention, a single patent application is filed and examined. The European Patent Office makes the decision on patentability which, if favourable, results in a national patent in each of the European countries designated by the applicant. The African Intellectual Property Organization has the power to grant a single patent which has effect in all of its Member States. The European Patent Organization and the African Intellectual Property Organization, both of which provide for patents with regional effects, constitute exceptions to the generally exclusively national scope of patents.

3. HOW PATENTS MIGHT BE MANAGED BY WHO

WHO's patents could be licensed on appropriate terms to undertakings chosen by WHO to develop and/or manufacture its patented inventions, and, to further the public interest, could be licensed to Member States, other international organizations, and non-profit entities.

WHO should have a single organization-wide patent policy, which can be conveniently administered by the Office of the Legal Counsel. The staff of that Office currently includes a lawyer experienced in patent matters and in technological contracts. However, individual patent operations are best conducted in close contact with those who are intimately familiar with the relevant technology and market considerations, that is, with those at the programme level. At least initially, the preparation and the actual prosecution of patent applications should be entrusted to national patent lawyers or agents engaged on "as needed" basis. The filing of each patent application and its prosecution should be monitored by the Office of the Legal Counsel. The funding necessary to obtain and maintain each patent should be provided by the programme concerned. Programme managers would thus include in their programme budgets the financial resources to be allotted to the programme's patent activities. If the matter is handled in this manner, it is not foreseen that the volume of work required of any one programme will require additional personnel.
4. PATENT POLICY OPTIONS

4.1 Patent policy options for WHO

At its sixty-ninth session in January 1982, the Executive Board considered various approaches to the matter of patents which might be followed by WHO.¹

One approach, which may initially appear attractive to some, would be to attempt to avoid as much as possible any involvement with patents. This approach would spare WHO the cost of procuring patents, protecting them, and exploiting them. However, even when accompanied by a programme of publication in a seeming attempt to dedicate WHO-sponsored developments to the public, it presents serious problems, because publication pre-empts patenting only to a limited extent. Where the results of the research published point to a pharmaceutical product which has commercial potential, profit-making concerns would be free to exploit the WHO-sponsored research for their private ends. Moreover, material so published will often be of a general nature, e.g., referring to a new family of chemical compounds likely to be useful for some desirable purpose. In preparing to enter the market, the profit-making concern would most probably identify the one member of the family that is best for the intended purpose, and would very likely be able to obtain patent protection on the one commercial species. Without a patent on the family as a whole, WHO would be powerless to influence the commercial exploitation by industry for the benefit of the public. Indeed, if WHO or any of its Member States wished to use that best compound in a country where the profit-making concern had a patent, they could do so only by virtue of a licence, for which royalties could be charged. Where the material published is specific and does place the best compound in the public domain, reputable high-quality manufacturers are reluctant to commit their resources to developing it to the point where it can be used in human therapy because they will have no means to ensure the return of their investment. The refusal by WHO to take out patents or permit the patenting of health inventions arising from WHO-sponsored research will, even when accompanied by publication, inhibit rather than promote the availability to the public of the fully developed physical embodiments (as opposed to merely the theoretical written description) of such inventions.

The other approach is for WHO, and the research institutions and pharmaceutical and other companies upon which it depends, to make use of the patent systems provided by various Member States. WHO should, whenever it can, itself obtain patents on significant inventions. As indicated above, WHO as the patent owner would be in an ideal position to find the most suitable manufacturers for the invention, thus providing WHO with maximum leverage on the issues of availability, price, and technology transfer. In many cases, however, the other party will be providing most of the resources (in cash or in kind) and will therefore be entitled to procure and own the patents. In such cases, the public sector interest can best be protected by contractual reservations to WHO of a licence, public sector sublicensing rights, rights to require the patent owner to grant licences to third parties where he does not practise the invention covered by the patent, and a share of the gross income attributable to the (partially) WHO-sponsored invention.

4.2 Disadvantages and advantages

The arguments against and for WHO ownership of and interest in patents were examined by the Executive Board and may be restated here.

Two negative areas can be considered: legal liability and loss of good reputation. No legal liability arises from owning or being licensed under a patent nor from simply licensing a patent that one owns. If an invention were, in practice, to prove to have unforeseen harmful side-effects, legal liability, if any, would arise not from any patent considerations but from the actual practice of the invention (that is, its production or promotion). So long as WHO follows the best available scientific and ethical practices, and does all within its power to ensure that parties with whom it has relationships do likewise, it will not be guilty of negligence in the legal sense. The reputation of WHO, however, is controlled not by what

¹ See document EB69/20. For the Board's comments, see document EB69/1982/REC/2, pp. 140-144 and 195-196.
WHO in fact does but rather by what others think of WHO. Some might say that for WHO to have an economic interest in a particular invention would make it difficult for the WHO Secretariat not to favour that invention, perhaps over equal or even better competing inventions. But WHO's judgements are based strictly upon technical considerations. Moreover, this risk appears to be especially low for WHO because no individual member of the WHO Secretariat would derive any personal economic benefit from any WHO patent. It might also be said that the desire to establish a remunerative patent position could slant research in the direction of commercially exploitable developments. This argument is adequately answered by the preceding comments. In any event, the practice in WHO's research and development activities to make use of independent advisory groups takes much of the relevant technical decision-making function out of the hands of the WHO Secretariat.

Negative considerations such as these cannot compare with the benefits to the continuing mission of WHO (set out in section 1 above) which could be achieved by the use of patent rights. WHO would obtain maximum leverage to make patents available to the public as widely and at as low a cost as possible. WHO would ensure to the extent possible that inventions, through the availability of patent licences, would be attractive subjects for practical development. It would, by taking royalties on its patents in cash or in kind, be able to get more for its research funds, resulting in more research and more health resources to make available to the public sector.

5. RESOLUTION RECOMMENDED BY THE EXECUTIVE BOARD

Endorsing these conclusions, the Executive Board adopted resolution EB69.R7, in which it recommended a draft resolution for adoption by the Thirty-fifth World Health Assembly.
IMPLEMENTING THE STRATEGY FOR HEALTH FOR ALL\textsuperscript{1}

\[A35/INF.DOC./7\ - 12\ May\ 1982\]

At the request of the delegation of Cuba, the President of the Thirty-fifth World Health Assembly has the honour to submit the attached communication to the Assembly for its information.

(a) Letter, dated 11 May 1982, from the delegation of Cuba to the President of the Thirty-fifth World Health Assembly

Geneva, 11 May 1982

Sir,

Please find enclosed four resolutions adopted by the Ministers of Health of the Non-Aligned and other developing countries, expressing their commitment to implement the Strategy for Health for All by the Year 2000. This subject is also included in the agenda (item 19) of the Thirty-fifth World Health Assembly.

We would appreciate if these resolutions could be circulated as an information document of the Thirty-fifth World Health Assembly.

Yours sincerely,

\(\text{\hspace{1em} (signed) Dr Luis Solá Vila}\)
\(\text{Ambassador, Delegate of Cuba to the Thirty-fifth World Health Assembly}\)

(b) Texts of the resolutions\textsuperscript{2}

1. IMPLEMENTATION OF NATIONAL STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000

The Sixth Meeting of Ministers of Health of the Movement of Non-aligned Countries and of other developing countries,

\textit{Bearing in mind} the realization in many Member States of the efforts needed to implement the goal of health for all by the year 2000;

\textsuperscript{1} See resolution WHA35.24.

\textsuperscript{2} Unofficial translation from the original Spanish.
Aware that if this goal is to be reached it is essential for Member States to devote all the resources needed to the development and implementation of appropriate national strategies;

Emphasizing the need to give priority to the least favoured areas by adequately organizing the infrastructure of health services, especially those designed to care for child growth and development;

Recognizing the important role to be played by the community in all the activities to ensure fulfilment of the health programmes;

Convinced that there is a lack of the information required for optimum implementation of the appropriate national programmes with a view to improving the health conditions of the vulnerable populations;

1. REQUESTS the Member States of the Movement, in the process of developing and implementing their national strategies, to lay emphasis on:

(a) the gradual reallocation of national resources for the benefit of the least favoured population groups and the socially depressed areas in every country in conformity with the principles of equity and justice inherent in the spirit of the social objective and concept of primary health care;

(b) extension of the health services infrastructure by giving priority to the least favoured areas and organization of services in such a way as to produce a clearcut impact in improving the level of health of the population in those areas, particularly by substantially reducing infant mortality and improving child growth and development. This could be achieved by:

(i) improving the environment, laying special stress on adequate safe drinking-water supply and basic sanitation, particularly in the rural areas;

(ii) promoting food supply and proper nutrition and controlling diarrhoeal, communicable and other endemic diseases prevalent in the country or area concerned;

(iii) achieving complete coverage of the population at risk with immunization against the main infectious diseases;

(c) promotion and support of community participation at all levels in the planning, financing, administration and control of health programmes;

(d) participation of all the social and economic sectors concerned in the process of achieving the social goal of health for all by the year 2000, integration of the health sector in the overall process of socioeconomic development and utilization of practical and effective means of intersectoral coordination;

(e) gradual reorganization of the national health system along new lines in accordance with the principles of primary care, including basically:

(i) the development of health manpower socially and technically capable of participating in the health-for-all process and directing it efficiently;

(ii) the use of appropriate technologies in line with the health needs of the least favoured population groups;

(iii) the use of practical and effective means of coordinating all the institutions and services making up the national health system;

(f) improvement of the information needed for planning, administering, supervising and evaluating health programmes, particularly those concerned with the areas mentioned in operative paragraph 1(b), and information on the effect of those programmes in improving
the health conditions of vulnerable populations such as women, children and the least favoured groups; and

2. REQUESTS the Director-General of the World Health Organization to ensure that the Secretariat at national, regional and global levels provides Member States with full support in the efforts described in operative paragraph 1 above.

2. TECHNICAL COOPERATION AMONG COUNTRIES
WITH A VIEW TO ACHIEVING THE GOAL OF HEALTH
FOR ALL BY THE YEAR 2000

The Sixth Meeting of Ministers of Health of the Movement of Non-aligned Countries and of other developing countries,

Considering the importance of achieving the social goal of health for all by the year 2000;

Bearing in mind that one of the ways of helping to achieve that goal is technical and economic cooperation among Member States of the Movement and other developing countries concerned with the action programme;

Convinced that, while the health problems confronting the developing countries are similar, there are differences between national health systems in respect of their degree of development and their programme achievements;

Aware that there are different types of activity that have achieved acceptable levels in certain countries in some areas of common interest, and that in the sphere of cooperation among Member States of the Movement and other developing countries concerned this would represent a tremendous technical and economic contribution;

Realizing that the action programme coincides with the postulates set forth in the Declaration and Recommendations of the International Conference on Primary Health Care held in Alma-Ata in September 1978;

Implementing the decisions in regard to health adopted by the Heads of State and Government of the non-aligned countries at the Sixth Summit Conference of the Movement;

1. REQUESTS Member States of the Movement:

(a) to take every opportunity that arises for technical cooperation among them, and especially among developing countries, in fields such as:

(i) research on and development of health systems, particularly in regard to:

- the development and utilization of health technologies suitable for primary health care, giving priority to those relevant to health needs among the least favoured population groups;

- reorientation of the health service infrastructure;

- specific aspects of programmes connected with safe drinking-water and basic sanitation, food supplies and adequate nutrition, control of diarrhoeal, communicable and other endemic diseases, and immunization against the main infectious diseases;

(ii) training and guidance of health personnel at all levels according to the requirements arising from the implementation of national plans of action;

(iii) exchange of information on specific national experience in regard to implementation of the strategies and plans of action for achieving health for all and in regard to TCDC activities;
(b) to promote the holding of high-level working meetings between countries with common boundaries, belonging to the same geographical region or interested in drawing up agreements for joint action with a view to undertaking practical cooperation in regard to:

(i) joint health programmes for the populations of neighbouring border areas and for migrant workers and their families;
(ii) joint health services and institutions of a bilateral, regional, etc., character;
(iii) specific programmes such as immunization, vector control and exchange of health manpower;

(c) to convene meetings of health experts with a view to finding feasible ways and means of resolving the problems and overcoming the constraints common to a certain number of countries, identified during the monitoring of progress and the evaluation of achievements in implementing the health-for-all action plans;

(d) to supply WHO with information on national experts, indicating their qualifications, special fields of experience, the countries in which they obtained their experience, and other pertinent data to facilitate their utilization in other countries;

(e) to consider the establishment of national funds, specially designed to support programmes and activities undertaken as part of technical cooperation among countries, such as a world network of national, bilateral and regional institutions for health development, the exchange of experts and fellowship programmes;

2. REQUESTS the Director-General of the World Health Organization:

(a) to strengthen the process of exchange of information and promotion of cooperative programmes among Member States, especially among developing countries, with a view to achieving the basic objectives of national strategies;

(b) to facilitate the dissemination of information on national experts from Member States, as requested in operative paragraph 1(d) above, with a view to promoting technical cooperation among countries through joint utilization of experts;

(c) to provide full support for activities of technical cooperation among Member States, and in particular those activities mentioned in operative paragraph 1 above.

3. NETWORK OF INSTITUTIONS FOR HEALTH DEVELOPMENT

The Sixth Meeting of Ministers of Health of the Movement of Non-aligned Countries and of other developing countries,

Realizing that exchange of information and experience and of research results in the field of health is a prime element in the development of national strategies and a necessary step for cooperation between developing countries;

Bearing in mind that national health development institutions have proved to be one of the effective means of implementing national programmes;

Aware that a worldwide network made up of bilateral and regional institutions for health development would play an important role in achieving the goal of health for all by the year 2000;
1. REQUESTS the Member States of the Movement:

(a) to establish, reorganize and strengthen national health development institutions as a practical means of ensuring the development and implementation of processes for achieving the goal of health for all by the year 2000, bearing in mind their possible role as bilateral or regional institutions within a worldwide network;

(b) to reach agreements between Member States for the recognition of bilateral or regional institutions for health development. Such institutions would have as their objective:

(i) facilitation of the exchange of information on important experience derived from the implementation of national strategies for health for all and primary health care;

(ii) promotion and completion of research on health systems in line with the needs of the countries concerned;

(iii) promotion and development of training and guidance programmes for health personnel at all levels and particularly for those who will be responsible in the future for promotion, management and technical support in implementing the national strategy and action plans for health for all; and

(iv) provision of technical cooperation for participating countries, particularly through the utilization of health experts available throughout the world;

2. REQUESTS the Director-General of the World Health Organization to facilitate international coordination between institutions for health development to form part of the worldwide network.

4. EXCHANGE OF HEALTH EXPERTS BETWEEN DEVELOPING COUNTRIES

The Sixth Meeting of Ministers of Health of the Movement of Non-aligned Countries and of other developing countries,

Bearing in mind that the exchange of experts between developing countries is a very effective means of technical and economic cooperation between those countries;

Convinced that the exchange of experts between countries with similar socioeconomic and health problems is of greater utility in this type of cooperation;

Recognizing that in some developing countries sufficient experience has been accumulated in certain types of programmes and other areas of health management, a knowledge of which would be of great benefit to others;

Considering that several meetings of the developing countries have recommended the forwarding to WHO of information on experts from the countries concerned who possess adequate scientific and technical skills and experience in their particular fields of work at the national or international level;

REQUESTS the Director-General of the World Health Organization:

(a) to set up the necessary machinery for receiving and evaluating the information on experts that the Member Countries of the Movement have been requested to send to him;

(b) to distribute among the developing countries the lists of experts which he receives through WHO regions or directly from the countries of the Non-aligned Movement and other developing countries concerned;
(c) to pay special attention to including in that information the national and international experience which, according to the countries, these experts have in their field of competence;

(d) to facilitate technical and economic cooperation among developing countries through the utilization of experts, by supplying this information regularly every year, independently of whether knowledge of the movements and availability of the personnel concerned has been kept up to date or not.
I. INTRODUCTION

1. The Thirty-third World Health Assembly, in May 1980, adopted resolution WHA33.32 endorsing the statement and recommendations made by the joint WHO/UNICEF Meeting on Infant and Young Child Feeding, held in Geneva in October 1979, and emphasizing the need for urgent action by governments concerning infant and young child feeding. The resolution requested the Director-General to intensify activities in the areas described in the statement and recommendations and to submit to the Thirty-fourth World Health Assembly, in 1981, and thereafter in even years, a report on the steps taken by WHO to promote breast-feeding and to improve infant and young child feeding.

2. In 1981 the Thirty-fourth World Health Assembly adopted the International Code of Marketing of Breast-milk Substitutes in the form of a recommendation in the sense of Article 23 of the WHO Constitution.\(^1\)

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1. See resolution WHA35.26.
3. The present report provides information available to WHO on action taken in the field of infant and young child feeding as part of its regular programme of activities in this area, in response to specific points raised in resolution WHA33.32, and as a follow-up to the International Code. As in the first progress report,1 presented to the Thirty-fourth World Health Assembly, the five-theme framework used during the WHO/UNICEF meeting in October 1979 has been retained as the basic outline. These five themes are:

- 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, 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 feeding;
- the appropriate marketing and distribution of breast-milk substitutes.

4. It is important to recall that the activities described in this report are not carried out in isolation, but as part of the larger programme of family health as a component of primary health care, 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. This overall programme constitutes an essential element of the strategy for health for all by the year 2000; the actions described below thus complement the WHO activities of technical cooperation with countries, carried out in collaboration with UNICEF, UNFPA, and other United Nations bodies.

Preparation, distribution and review of "Guiding principles for facilitating reporting by Member States on action taken in the field of infant and young child feeding"

5. During the discussions on the International Code at the Health Assembly and the Executive Board in May 1981 the Director-General was asked to prepare guidelines which would facilitate Member States' monitoring of and reporting on action taken at the country level to give effect to its principles and aim. Bearing in mind the Assembly's emphasis on the Code's being viewed within the framework of the problems of infant and young child feeding as a whole, a set of guiding principles was prepared, in time for consideration by the 1981 regional committee meetings, to cover the broad aspects of infant and young child feeding as in the five themes referred to above, thereby facilitating action to be taken by all concerned, including regular reporting.2

6. The guiding principles were designed for use both as a "check list" for governments to monitor progress achieved in improving the health and nutritional status of infants and young children and as a means of facilitating assessment of action taken. They were distributed to Member States as part of the documentation prepared for the 1981 regional committee meetings. The Regional Committees for South-East Asia, Europe and the Western Pacific adopted resolutions3 urging Member States inter alia to make appropriate use of the guiding principles in carrying out the action recommended in Health Assembly resolutions WHA33.32 and WHA34.22.

7. In preparation for the 1981 regional committee meetings, Regional Directors facilitated the holding of national consultations to review the guiding principles in India, the Philippines and Zaire. As a result an interministerial working group was formed in India.

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1 Document A34/7.
2 See Article 62 of the Constitution of WHO concerning reporting by Member States on action taken with respect to recommendations made to them by the Organization. See also Article 11.6 of the International Code of Marketing of Breast-milk Substitutes, and paragraph 74 of the present report.
3 Resolutions SEA/RC34/R8; EUR/RC31/R5; and WPR/RC32.R11.
to review information on infant feeding practices, and to determine the need for further data and ways in which these data can be translated into national action designed to promote better infant and young child feeding and nutrition. In the Philippines discussions led to the preparation of a long-term plan of action on infant and young child feeding, including the development of measures to give effect to the International Code. In Zaire recommendations were made for future activities in the area of infant feeding, including action with respect to the International Code. In addition, on the basis of the guiding principles, the Netherlands prepared a detailed report on the national situation with respect to infant and young child feeding and presented it to the September 1981 session of the Regional Committee for Europe.

8. The consensus emerging from these discussions, at both the national and regional committee levels, is that the guiding principles constitute a useful basis for country reporting; that they focus on the types of national actions which are most likely to improve infant and young child feeding practices; and that they emphasize the need for increased coordination and cooperation between different sectors in the area of infant and young child feeding.

A note on the process of the preparation of future reports by the Director-General relating to infant and young child feeding

9. The present document, like the first progress report to the Health Assembly in 1981, has been prepared on the basis of information available to WHO. As a preliminary step leading to the first full reporting cycle on the subject based on country reports, the Director-General intends to revise the guiding principles for reporting, taking into account the comments of Member States made during the regional committee meetings and the national consultations held in 1981. The revised guiding principles will be distributed as part of the 1982 regional committee documentation. It is hoped that they will be of yet greater utility to Member States in monitoring progress achieved in attaining their individual objectives and goals; in reformulating them where necessary; and, as a common reporting guide for all Member States, in facilitating the preparation of national reports on action taken, in time for their consolidation and presentation to the regional committee meetings in 1983.

10. The regional reports so prepared will, in turn, be forwarded to the Director-General following their discussion by the regional committees, and will be used as a basis for his report to the Thirty-seventh World Health Assembly in May 1984 in conformity with Health Assembly resolution WHA33.32 and Article 11.7 of the International Code of Marketing of Breast-milk Substitutes. This same process will be repeated as part of the regular biennial reporting procedure, thus permitting the Director-General to base his progress reports directly on information provided by Member States themselves.

11. In this connexion, it will be recalled that the Thirty-fourth World Health Assembly requested the Director-General to report on a one-time basis to the Thirty-sixth World Health Assembly in May 1983 "on the status of compliance with and implementation of the Code at country, regional and global levels"; and, "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". The Director-General will prepare this report to the Thirty-sixth World Health Assembly on the basis of consultations with Member States.

12. The Director-General has also been requested to report to the Thirty-sixth World Health Assembly on progress achieved in giving effect to resolution WHA34.23, on the nutritional value and safety of products specifically used for infant and young child feeding.

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1 See paragraph 74.
2 Resolution WHA34.22, paragraphs 5(3) and 5(4).
3 See paragraphs 157 and 158.
II. THE ENCOURAGEMENT AND SUPPORT OF BREAST-FEEDING

Promotional activities

13. The organization of national and regional multisectoral workshops, including participation from nongovernmental organizations, continues to be one of the principal mechanisms for promoting activities designed to encourage and support breast-feeding. Emphasis is placed on the role breast-feeding plays in the overall growth and development of infants and its importance for national health nutrition. Experience confirms the special value of workshops for generating practical recommendations which can be translated into programmes aimed at furthering public and professional awareness of the importance of breast-feeding. In keeping with the principles of technical cooperation among developing countries (TCDC), such activities also help to foster interregional and intercountry collaboration in this area.1

14. In the African Region 36 countries are participating in a programme of educational and informational activities; national strategy sessions have been held in the Central African Republic, the Congo, Ethiopia, the Gambia, Ghana, Liberia, Nigeria, Sierra Leone, and Zaire. The report of the Congo meeting has been distributed to all countries of the Region. Implementation of the programme will continue through 1982 and 1983 with emphasis on linkages between the various national programmes and an exchange of information between other national and regional programmes.

15. As part of the promotion of breast-feeding in the Region of the Americas in 1979-1980 a regional task force was established to coordinate research and promotional activities and facilitate intercountry collaboration. The second meeting of the task force was held in Lima, Peru, in November 1981 when it prepared a three-year plan of action based on the recommendations of the WHO/UNICEF Meeting on Infant and Young Child Feeding. The task force identified collaborating centres to assist in future activities in this area; modified the methodology2 developed for the surveillance of breast-feeding practices based on an assessment of the Region's needs and resources; and proposed a series of research and promotional activities for selected countries.

16. In Guatemala WHO is providing financial support to the Ministry of Health's National Commission on Breast-feeding for the organization of local workshops and seminars for obstetricians, paediatricians, nurses, midwives, legislators and policy-makers, with a view to increasing their awareness of the importance of breast-feeding and of the actions they may take to encourage it.

17. In October 1981 the Ministry of Health and Environment in Trinidad and Tobago, in collaboration with the Caribbean Food and Nutrition Institute and WHO/PAHO, conducted a workshop on strategies to promote successful breast-feeding. The workshop, attended by 90 participants, had three objectives: to highlight available data on current breast-feeding practices in the country; to identify factors hindering breast-feeding and those enhancing it; and to develop a national strategy and plan of action for the promotion of breast-feeding. Similar workshops have been held in a number of other countries in the Caribbean.

18. Activities in the South-East Asia Region relating to the encouragement and support of breast-feeding have also been pursued through national workshops and seminars. A regional workshop was held in Sri Lanka in April 1981, in collaboration with WHO, for policy-makers from health and other development sectors, and nongovernmental organizations. The workshop proposed the establishment of a regional task force whose main objective would be to facilitate intercountry collaboration in promotional and research activities, especially breast-feeding surveillance, and in the preparation of studies on health care practices and training curricula.

19. The WHO Regional Director for South-East Asia and UNICEF Regional Director for South-Central Asia addressed a joint letter in January 1982 to all parliamentarians, paediatricians

1 See paragraph 58 concerning the preparation of a handbook on the organization and management of workshops.
2 See paragraph 30.
and obstetricians in India in which they announced their decision to launch a campaign to
further the principles and aim of the International Code of Marketing of Breast-milk Substitutes
as part of their regular programmes to promote proper infant and young child feeding
practices. Addressees were invited to join in this effort to reduce malnutrition, morbidity
and mortality; a copy of Infant and young child feeding - current issues (see paragraph 57)
was sent to them for information.

20. In the European Region the Government of Norway has seconded to the Regional Office, on
a part-time basis for two years, one of its Health Directorate nutritionists to assist in
developing regional infant and young child feeding activities, including the promotion of
breast-feeding. A consultant has been engaged by this office to undertake a worldwide
literature survey of comparative morbidity rates between bottle- and breast-fed infants in
industrialized countries. The results of this survey will be distributed to all Member
States in the Region with a view to promoting awareness of the importance of fostering and
protecting breast-feeding.

review breast-feeding in the countries of the Eastern Mediterranean Region. Experts from
Cyprus, Democratic Yemen, Egypt, Jordan, Lebanon, Pakistan, Saudi Arabia, Sudan and Yemen
drew up plans for surveys on the prevalence and duration of breast-feeding, health
education of the public (including the possible establishment of women's voluntary
organizations) to encourage breast-feeding, and the provision of information for health
workers. The Group reviewed maternity and lactation leaves for working mothers and the
application of the then-draft International Code of Marketing of Breast-milk Substitutes in
the countries of the Region. Suggestions were made for practical action by national health
authorities to encourage breast-feeding, including a total ban on advertising of breast-milk
substitutes to the general public; continued distribution of the WHO brochure\(^1\) on breast-
feeding to health workers and to interested lay persons and associations (e.g. women's
organizations); organization of short in-service seminars on breast-feeding and related
subjects for health personnel; review and reinforcement, where necessary, of health worker
training curricula; and establishment of rooming-in as standard practice in health
facilities. The Group's recommendations form the basis of the regional infant and young
child feeding programme which has been translated into a plan of action for the period

22. The Government of Afghanistan is preparing a national breast-feeding campaign, with
the support of WHO and UNICEF, including a seminar for Ministry of Public Health officials.
UNICEF has translated the International Code, the WHO brochure on breast-feeding, and an
article entitled "When the answer is not the bottle" into Pushtu and Dari for use in this
campaign. In addition, three different slide/sound presentations have been translated and
dubbed in Dari for use in media programmes and seminars, and by women's organizations.

23. Efforts to develop national programmes to promote breast-feeding in the countries of
the Western Pacific Region include plans for an international seminar on the subject to be
held in China later this year. This will provide an opportunity for updating scientific
information on breast-feeding and for reviewing progress achieved in carrying out the
recommendations of the WHO/UNICEF Meeting on Infant and Young Child Feeding.

24. In Fiji, where a nursing mothers' association has been formed, breast-feeding is being
promoted through the radio, newspapers and in the cinema. A national food and nutrition
plan which demonstrates an increased awareness of the importance of infant and young child
feeding is being developed in collaboration with WHO, FAO and UNDP, and in this connexion a
workshop was held in July 1981 with WHO support.

25. A three-year plan of action for the promotion of breast-feeding has been drawn up in
Hong Kong and a national task force, composed of Ministry of Health officials, health
professionals and representatives of nongovernmental organizations, has been formed. A
public education campaign is under way and health workers are being trained specifically to
promote breast-feeding. The Government has implemented a task force recommendation
concerning additional maternity leave for working mothers.

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\(^1\) See paragraph 55.
26. A study of maternal attitudes towards lactation and weaning is under way in Papua New Guinea. Also, a national intersectoral workshop on infant and young child feeding, held in Port Moresby in January 1982 with the support of WHO, has recommended to the Government that follow-up studies on infant and young child feeding practices be undertaken and efforts made to enforce its policies strictly. The next national survey is expected to review the effectiveness of national infant and young child feeding policies, including that concerning the marketing and distribution of breast-milk substitutes (see paragraph 144).

27. In the Philippines a comprehensive long-term infant and young child feeding plan has been developed, including an educational programme for key Ministry of Health officials, health workers, and personnel of nongovernmental organizations. The programme includes surveys of the knowledge of, and attitudes towards, breast-feeding among health workers, and a series of seminars and training sessions for all health personnel cadres.

28. An international symposium on strategies for promoting breast-feeding was held in Tunis in December 1980, organized jointly by the Tunisian National Institute of Child Health, WHO, and the International Children's Centre (Paris). Some 40 health professionals from eight African, European and Eastern Mediterranean countries and a number of representatives of international and nongovernmental organizations participated. The meeting's overall objective was to contribute to maternal and child health promotion through an improvement in maternal and young child feeding practices and related social support systems.

29. WHO provided financial support for participants from Indonesia and Kenya to attend a nursing mothers' international workshop organized in Sydney in March 1981 by the Nursing Mothers' Association of Australia for organizations in Africa, South-East Asia and the Western Pacific. The main purpose of the workshop was to foster the ideal of the physical and emotional health of mother and child through breast-feeding by providing a forum for voluntary self-help associations of nursing mothers of the three regions.

Research activities

Breast-feeding surveillance methodology

30. Further to the protocol developed for the WHO collaborative study on breast-feeding,¹ and in response to resolution WHA33.32, a methodology for the determination of breast-feeding patterns has been developed. This methodology, as outlined in a WHO document,² is intended for national adaptation and use in a wide variety of settings for the collection of comparable data both within and among countries. It includes: (a) the rationale for the collection of breast-feeding data; (b) the use of these data as social and health indicators; (c) potential sources of information; (d) alternative ways of gathering the required information; and (e) a protocol for use at the national level in conducting surveys based on prevailing sociocultural patterns.

31. The methodology has been evaluated in Jamaica, Paraguay, Portugal, and Sri Lanka. Together with a small group of consultants, the national principal investigators will meet in Jamaica in May 1982 to report on the evaluation in their respective countries and make proposals for modifications in the overall methodology on the basis of experience. The results of the pre-test, together with proposed changes, will be incorporated in a final document and a companion handbook on survey design; the document will include a programme for micro-computer data processing. Modules dealing with related questions such as diarrhoeal diseases, contraceptive practices, and the use of health services are also available for use with this methodology.

32. Following discussions with Ministry of Health officials, WHO has agreed to support the Government of Nepal's efforts to collect and analyse data concerning breast-feeding and weaning, and associated morbidity and mortality. This is being done through the addition of a relevant module to the national fertility survey undertaken by the Ministry's Division of Maternal and Child Health and Family Planning.

² Document MCH/BF/SUR/81.1.
33. WHO is collaborating in a number of other countries in the development of breast-feeding surveillance systems: in Kenya, together with UNICEF and the Central Statistics Bureau (WHO and UNICEF are also organizing a regional workshop on the social and economic aspects of breast-feeding, to be held in Nairobi in late 1982); in Mauritius, with the Ministry of Health and UNICEF; and in Peru, with the Ministry of Health and the Peruvian Paediatric Association.

34. In Argentina the Ministry of Health has set up a ministerial task force to promote and coordinate the monitoring of breast-feeding in various regions. As part of this exercise, WHO is supporting the development of training manuals on clinical management and the encouragement of breast-feeding. The Government of Venezuela will include a module on breast-feeding and weaning in the interview schedule being prepared as part of the first national census of its indigenous populations in 1982. A breast-feeding monitoring programme is being set up under the auspices of the University of Coimbra (Portugal), as part of a collaborative network including institutions in Brazil and countries of Portuguese-speaking Africa, planned for 1983. Breast-milk volume and composition studies are being completed in Guatemala, Hungary, the Philippines, Sweden, and Zaire, and a similar study is being planned in China (Shanghai Children's Hospital).

35. WHO collaboration with the Institute of Nutrition in Alma-Ata, USSR, in a three-year programme of research on the nutrition of infants and the obese was begun in early 1982. The work includes a review of existing data on the prevalence and duration of breast-feeding in the southern USSR, on aspects of present health care and the training of health manpower that are relevant to breast-feeding, and on the association between breast-feeding and obesity; and the establishment of a breast-feeding monitoring system using WHO's methodology. Research on human milk includes studies on composition outside normal lactation patterns, on the prerequisites for the use of raw human milk in milk banks, on pesticide levels, and on immunological aspects. The municipalities of Moscow and Kiev are also applying the methodology in collaboration with WHO in the analysis of data on the prevalence and duration of breast-feeding.

36. Valuable information regarding breast-feeding and weaning practices in the South-East Asia Region has been derived from the WHO-supported collaborative study on the outcome of pregnancy, including perinatal mortality and low birth-weight. This information will be used for developing intervention strategies in the WHO collaborative study on the risk approach to the delivery of maternal and child health care.

**Health services research regarding breast-feeding**

37. The relationship between health care services and infant feeding practices, highlighted by the WHO collaborative study and the WHO/UNICEF Meeting on Infant and Young Child Feeding, has received increasing attention in recent years. Accordingly, a methodology is being developed, including a core survey protocol and a set of data collection guides, to support national institutions' efforts to measure health care services' impact in this respect. In addition, guidelines have been prepared which are designed to ensure that health care practices provide the type of support breast-feeding mothers need during the prenatal, interpartum and postpartum periods.

38. A longitudinal study is under way in collaboration with the Department of Paediatrics and Epidemiology at the University of Beer Sheeva, Israel, and the Centers for Disease Control, Atlanta, United States of America, to examine the relationship between maternal nutrition, infant feeding practices, nutritional status and morbidity. Similar studies are to be carried out in two other countries. At the Shanghai Children's Hospital, China, a study is under way on breast-feeding prevalence and duration and associated factors, other infant feeding practices, and the volume and composition of breast-milk produced by mothers from different occupational backgrounds. These studies will provide data comparable with those resulting from phases I and II of the WHO collaborative study.

39. The frequency with which mothers reported "milk insufficiency" in the WHO collaborative study has highlighted this issue as a priority problem. The fourth meeting of the Consultative Group on Maternal and Young Child Nutrition\(^1\) of the Administrative Committee on

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\(^1\) WHO, FAO and UNICEF are participating in the Consultative Group. See also paragraphs 53 and 70.
Coordination's Sub-committee on Nutrition (AG/C/SCN) (Geneva, August 1981) considered that early clarification of this issue was essential if appropriate breast-feeding management guidelines were to be issued. A preliminary consultation to review "milk insufficiency" and to prepare a protocol for a collaborative study on the subject will be held at WHO headquarters later in 1982.

40. A consultation is scheduled to be held in Geneva in May 1982 to prepare guidelines for the feeding of low birth-weight and pre-term infants under different technological and economic conditions. It will review the nutritional needs and physiological characteristics of these infants; evaluate the influence of different feeding methods on their health and wellbeing; and review the economic and technological implications of different approaches for different settings.

41. WHO participated in the Canadian International Development Research Centre's August 1981 planning meeting to review its support of activities in the field of infant and young child feeding and to formulate relevant strategies for the next four years. It has been agreed that the Centre will focus on the development of standardized protocols for basic research in such areas as a methodology for the analysis and measurement of the quantity of breast milk.

42. In Mexico a WHO study on physicians' attitudes towards breast-feeding has recently been completed and a similar study on mothers' attitudes is under way; the results will be used to develop action programmes.

43. In view of the link between breast-feeding and nutrition, immunological protection and child spacing, WHO's work regarding breast-feeding has been closely coordinated with all relevant current activities in nutrition, immunization, diarrhoeal disease prevention, and research in fertility regulation. Wherever possible, national projects for the promotion of breast-feeding surveillance are implemented in conjunction with projects in these related fields.

44. WHO is collaborating with Hacettepe University Children's Hospital and the International Children's Centre in Ankara, Turkey, in the development of studies on morbidity related to infant feeding, especially with regard to gastroenteritis and bronchopneumonia.

III. THE PROMOTION AND SUPPORT OF TIMELY COMPLEMENTARY FEEDING (WEANING) PRACTICES WITH THE USE OF LOCAL FOOD RESOURCES

45. WHO country and regional activities relating to weaning with the use of locally available and acceptable foods continued to be developed in 1981-1982 in the African Region, the Region of the Americas, and the South-East Asia and Western Pacific Regions. The overall objective has been the drawing up of a methodology for nutritional activities in primary health care including the development of techniques for studying weaning practices; determinants of child feeding practices and their improvement, using local resources; the study of maternal attitudes to lactation and weaning; and practical methods for monitoring the nutritional status of children at the community level and for the promotion of local weaning foods.

46. Action-oriented research on infant feeding began in mid-1981 in Colombia with a view to using locally available resources more effectively to relieve nutritional problems through the combined participation of the primary health workers and families and communities themselves. A WHO-supported project is examining current infant and young child feeding patterns from birth to 36 months, associated socioeconomic, cultural and biological factors, and the relationship between feeding practices and nutritional status. It will identify specific problems in child feeding patterns amenable to improvement through community-based action either by individual citizens or through the primary health services, and develop simple methodologies for the evaluation of these patterns.

47. A WHO-supported study of attitudes to lactation and weaning has been under way in Papua New Guinea since early 1981. The study is designed to determine the attitudes and

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1 See paragraphs 59-61 concerning breast-feeding and fertility regulation.
beliefs of adults, particularly women, about growth and weaning, and their relationship to actual child feeding practices and growth. The information gathered will be used in planning nutrition activities; in developing health - including nutrition - education programmes; and in planning the nutrition activities of primary health workers.

48. The Government of Brazil is using a simplified version of the WHO methodology to collect information on breast-feeding and weaning practices in support of programme implementation, and is also adapting WHO/PAHO guides on infant and young child feeding to cultural patterns.

49. One of the proposed areas for research in the South-East Asia Region concerns the identification of constraints to adopting appropriate weaning practices, the improvement of methods of food preparation and preservation in the home, and means of increasing the time available to family members for child care and rearing. The search for solutions for these aspects of the overall problems related to infant and young child feeding is being promoted through action-oriented research programmes. This effort will be further stimulated when the establishment of a proposed network of nutritional centres in the Region has been completed.

50. Also in the South-East Asia Region, WHO is conducting a multi-centre study of attitudes and behavioural patterns affecting infant and young child rearing - including feeding practices, the determinants of the attitudes and behaviour of primary health workers towards their work, and of those of the public towards health workers. The purpose of this study is two-fold: (a) to improve understanding of the role played by attitudes and behaviour in infant and young child feeding practices and, in particular, the extent to which health workers are aware of these constraints and take them into account in their feeding and nutrition education activities; and (b) to improve the correlation between health workers' training curricula and the development of positive attitudes and behavioural patterns among health workers and, through them, the general public. Following the preparation of a report on infant and young child rearing practices in countries of the Region, it is planned to hold an intercountry workshop to prepare guidelines for the development of infant feeding components of health workers' training curricula in the light of local sociocultural patterns. (See also section IV of this report with respect to education and training.)

51. The Government of the Maldives, with the support of WHO and UNICEF, has recently launched an action-oriented nutrition research project to identify the extent of the infant and young child feeding problem and other nutrition issues that call for immediate action.

52. WHO has provided financial support for a study undertaken jointly by the Nutrition Research Institute in Lima, Peru, and the Center for Vaccine Development of the University of Maryland School of Medicine, United States of America, on the development of nutritious and hygienic weaning foods as a means of reducing diarrhoea and malnutrition among young children in Peru.

IV. THE STRENGTHENING OF EDUCATION, TRAINING AND INFORMATION ON INFANT AND YOUNG CHILD FEEDING

53. The ACC/SCN Consultative Group on Maternal and Young Child Nutrition, at its August 1981 meeting, reviewed progress achieved in the preparation of the third edition of the Manual on Feeding Infants and Young Children, which is directed towards doctors, nurses, home economists and nutritionists, especially those engaged in the training and supervision of primary health workers.

54. The WHO Scientific Working Group which met in Cyprus in January 1981 (see paragraph 21) discussed the production and distribution of teaching and learning materials in Arabic and other local and national languages of the Eastern Mediterranean Region. These materials cover such topics as breast-feeding and infant feeding in general, as well as child health, growth and development; the early detection of malnutrition; and diarrhoeal disease and oral rehydration. The Eastern Mediterranean Regional Office has already distributed widely Health care and nutrition of the young child in English (also translated into Arabic) and the WHO/UNICEF booklet Messages for mothers in English and Arabic.
55. The WHO brochure on breast-feeding continues to enjoy wide popular success. It is available in Arabic, English, French, Portuguese and Spanish, and will be translated at a later date into Chinese and Somali. The original press-run of 10,000 copies in Arabic has been exhausted and additional copies are being printed. The brochure has also been translated, in collaboration with UNICEF, into Dari, Pushtu and Urdu, and into Amharic by the Ministry of Health in Ethiopia, with WHO providing financial support for its reproduction.

56. A number of practical informational and educational tools relating to infant and young child feeding are in preparation, including a slide/sound presentation on breast-feeding designed for policy-makers and health professionals which is to be translated into the Organization’s official languages. A handbook on the organization of pre- and post-natal maternity care with special reference to breast-feeding and a popularized version of the background paper and report of the WHO/UNICEF Meeting on Infant and Young Child Feeding will be available later in 1982.

57. Since it was first made available in early 1981 nearly 15,000 copies of the WHO/UNICEF information document, Infant and young child feeding - current issues, have been distributed worldwide. This document is based, with appropriate modifications, on the background paper prepared for the WHO/UNICEF Meeting. It consists of two parts: a development of the meeting’s five themes (see paragraph 3), and background information relevant to a discussion of infant feeding (for example, concerning nutritional requirements in infancy, and supplementation and weaning). The Director-General of Health of Portugal has undertaken to translate the document - available originally only in English - into Portuguese; this will no doubt be valuable also for Portuguese-speaking countries in the African Region and the Region of the Americas.

58. A handbook on the organization and management of workshops on infant and young child feeding is being prepared by WHO to support countries and regions in promoting educational activities that were previously undertaken at the interregional level. The handbook, which will be available in English, French and Spanish, is intended for use in the organization of breast-feeding programmes at all levels of the health care system.

59. A workshop on breast-feeding and fertility regulation was organized jointly by WHO and the United States National Academy of Sciences (Geneva, February 1982) to review current knowledge on the possible interactions between hormonal contraceptive preparations and lactation; consider the role played by lactational amenorrhoea in fertility regulation; and formulate recommendations for programme policies and guidelines on breast-feeding and fertility regulation.

60. The workshop concluded that breast-feeding and family planning, adapted to local needs and circumstances, should be seen as mutually reinforcing parts of any health programme aiming to improve the health of mothers and children; and that breast-feeding should be actively promoted for its nutritional benefits, as a means of enhancing resistance to infection among infants and, as a consequence of lactational amenorrhoea, for its effects on prolongation of birth intervals. The choice of contraceptive method during lactation requires particular attention; for example, the use of certain hormonal contraceptives should be subject to due consideration of their potential adverse effect on the volume of breast-milk yield and the subsequent effects on duration of breast-feeding and length of lactational amenorrhoea.

61. Immediately following the workshop a three-day meeting of health policy-makers from 20 WHO Member States was held to review the recommendations for health policies and guidelines, and discuss ways and means of adapting them to national integrated maternal and child health, family planning, and nutrition programmes.

62. The Eastern Mediterranean Regional Office has produced a comprehensive review of breast-feeding as part of its Technical Publications Series. Prefaced by a historical essay, the


study covers 22 countries and areas in the Region, and reviews published and unpublished survey data and other materials on the subject of infant feeding, with special emphasis on breast-feeding. Its purpose is to establish a baseline of present knowledge from which future research and evaluation activities could logically develop, and to provide policy-makers with a solid foundation for programme planning and implementation. The review was the main document on the subject made available to the Scientific Working Group referred to in paragraphs 21 and 54.

63. The education and training of health workers with respect to breast-feeding and infant nutrition has been emphasized as part of the revised undergraduate paediatric curriculum on maternal and child health for medical students and interns in Sri Lanka. With WHO's technical support, greater emphasis is being placed on this subject in the curriculum content of national basic and reorientation training programmes in maternal and child health and family planning for different levels of health workers and extension workers in health-related fields. Steps are also being taken to give greater attention to breast-feeding and infant nutrition in the nursing/midwifery training of traditional birth attendants; this aspect was considered at an intercountry consultative meeting held at the Regional Office for South-East Asia in March 1981.

64. In the South-East Asia Region WHO has also begun work on the preparation of annotated bibliographies concerning breast-feeding studies undertaken in a number of countries, including Sri Lanka and Thailand. A handbook on the care of children has been prepared with due emphasis on breast-feeding, and will be tested as a tool for implementing changes in paediatric curricula. WHO is also providing support to the Government of Bangladesh for a review of basic and post-basic nursing curricula including elements concerning infant and young child feeding.

65. The identification and development of appropriate teaching and learning materials relating to specific maternal and child health and family planning activities remains an important support element for country training programmes for various categories of health workers, including traditional birth attendants and other community health personnel. WHO is assembling material dealing with such topics as breast-feeding, appropriate weaning practices, contraception, the monitoring of growth and development, and the risk concept in maternal and child health and family planning care into a series of 12 to 15 "teaching packages". Together with guides for their effective use, these materials are aimed at helping teachers and supervisors to plan and execute short refresher courses for health personnel and improve existing training curricula; they will be made available to country projects and training institutions.

V. THE DEVELOPMENT OF SUPPORT FOR IMPROVED HEALTH AND SOCIAL STATUS OF WOMEN IN RELATION TO INFANT AND YOUNG CHILD FEEDING

66. The successful promotion of appropriate infant and young child feeding practices is in large measure related to the conditions of women's lives. Women are more capable of providing for the nutritional needs of their children when their own socioeconomic, health and nutritional status is secure; where adequate social support measures exist; and to the extent that objective information concerning infant and young child feeding is readily available to them.

67. In this respect a two-year (1982-1983) programme of work with three main objectives has been drawn up by WHO and UNICEF: (a) improved awareness and understanding of how women are affected by such factors as work patterns and economic constraints, their health and nutritional status, reproductive patterns and family structures; (b) increased involvement of women's organizations in the promotion of appropriate infant and young child feeding practices as part of primary health care; and (c) promotion of community support measures for women and families.

1 Afghanistan, Bahrain, Democratic Yemen, Djibouti, Egypt, Gaza, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Oman, Pakistan, Qatar, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen.
68. Activities within this programme already under way include: (a) a review of the extent and coverage of maternity legislation; (b) the preparation of analytical papers on social measures (including the economic, social and health implications of maternity protection legislation and day-care for children) and the nature, extent and effectiveness of community-level support mechanisms; (c) the development of guidelines for use by national women's organizations and other groups to support their efforts in carrying out surveys of factors affecting women's breast-feeding, reviewing existing social support measures, and assessing the types of new measures which may be required (currently being tested in Kenya with the collaboration of the Kenyan National Council of Women); (d) the preparation of a promotional booklet entitled Women and breast-feeding,¹ for distribution to nongovernmental women's organizations and other advocacy groups; and (e) the publication of a position paper on the status of women and weaning in relation to the practical and economic problems they face in preparing nutritious weaning foods, and on alternative solutions to these problems. (See also section III of this report in regard to weaning foods.) These activities are part of WHO's overall programme on women, health and development, the purpose of which is to increase awareness of the health needs and problems specific to women; of the role of women as health care providers; and of the interrelationships between women, health and development, in particular as regards their socioeconomic and cultural status.

69. Examples of support activities for women being undertaken at the regional level are the participation of women in primary health care through local village-level women's organizations (in the African Region); the endorsement by the twenty-eighth meeting of the PAHO Directing Council of a five-year plan of action (for the Americas); the promotion of information exchanges through country focal points (in the South-East Asia Region); activities on the role of women in lay health care and contributions to alternative health care approaches (in the European Region); the gathering, analysis and dissemination of information on traditional practices affecting women's health (in the Eastern Mediterranean Region); and the review of the roles of women's organizations in primary health care (in the Western Pacific Region). In addition, the African Study Group on Research in Human Reproduction, at its first meeting in Antananarivo, Madagascar, in June 1981, developed a programme on the participation of women in health and development which emphasizes maternal and infant feeding and support for working women.

70. Maternal nutritional needs and problems constituted the principal discussion theme of the ACC/SCN Consultative Group on Maternal and Young Child Nutrition in August 1981 (see also paragraphs 39 and 53). This theme was discussed with a view to developing action to improve nutritional status - including legislative and other social support measures,² education, increasing availability of food, reducing workload, improving health services, and overcoming acute nutrition-related problems and deficiencies - and identifying gaps in existing knowledge.

VI. THE APPROPRIATE MARKETING AND DISTRIBUTION OF BREAST-MILK SUBSTITUTES

71. When this report is discussed by the Thirty-fifth World Health Assembly, one year will have passed since the adoption of the International Code of Marketing of Breast-milk Substitutes in the form of a recommendation in the sense of Article 23 of the WHO Constitution. It will be recalled that the Thirty-third World Health Assembly had requested the Director-General in May 1980 to prepare an international code of marketing of breast-milk substitutes and to submit it to the Executive Board for consideration and for forwarding with the Board's recommendations to the Thirty-fourth World Health Assembly.

72. Member States of WHO and groups and individuals who had been represented at the WHO/UNICEF Meeting on Infant and Young Child Feeding were requested to comment on successive drafts of the code. Meetings were held in February and March and again in August and September 1980 in an effort to foster a continuing dialogue on both the form and the content of the draft code and to maintain as a minimum basis the points agreed upon by consensus at the October 1979 meeting.

¹ Based on the report of an informal consultation held in Geneva in November 1980; available in English as WHO offset document FHE/81.1.

² See section VIII concerning legislation.
73. In January 1981 the Executive Board considered the draft code and in resolution EB67.R12 unanimously recommended to the Thirty-fourth World Health Assembly the adoption of the code in the form of a recommendation rather than as a regulation; 1 on 21 May 1981, by resolution WHA34.22, the Health Assembly adopted the code by 118 votes in favour to 1 against, with 3 abstentions.

74. Article 11.6 of the International Code provides that "in accordance with Article 62 of the Constitution . . . Member States shall communicate annually to the Director-General information on action taken to give effect" to its principles and aim. Article 11.7 states that the Director-General "shall report in even years to the World Health Assembly on the status" of its implementation.

75. Although relatively little time has elapsed since its adoption, and the reporting mechanism 2 to the Director-General via the regional committees is not yet fully operational, there is evidence that many countries have taken relevant action. A number of countries had already adopted various legislative and other measures concerning the marketing and distribution of breast-milk substitutes prior to the adoption of the International Code; some of these have begun to modify and strengthen national measures in the light of the Code's provisions. Other countries, in all regions, are taking a variety of steps to adapt the principles and aim of the Code to their particular social and legislative frameworks since its adoption in May 1981.

76. This section summarizes action taken by Member States individually and, 'in a number of cases, collectively through regional and interregional forums, giving effect to the principles and aim of the International Code. This being the first report by the Director-General since the Code's adoption, the present section goes beyond the period since the last Health Assembly and contains information on action relevant to the marketing and distribution of breast-milk substitutes taken by Member States in recent years. Such an approach is necessary in order to establish a baseline by which future progress in this area may be measured. This section also discusses relevant initiatives taken by the WHO Secretariat and activities of the Joint FAO/WHO Food Standards Programme and its Codex Alimentarius Commission.

Publication and distribution of the International Code of Marketing of Breast-milk Substitutes

77. Following the Thirty-fourth World Health Assembly, in May 1981, copies of the International Code were formally transmitted to all Member States, together with resolution WHA34.22 by which it had been adopted, under cover of the Director-General's Circular Letter No. 16 of 24 August 1981. The International Code was also printed and distributed widely as a WHO publication in the six official languages. 3 In addition to the Code itself and a brief introduction describing the steps taken in its development since the WHO/UNICEF Meeting on Infant and Young Child Feeding, the publication contains resolutions WHA34.22 and WHA33.32 (on infant and young child feeding), as well as excerpts from the introductory statement on the subject by the representative of the Executive Board to the Thirty-fourth World Health Assembly.

78. Copies of the International Code have also been sent to all WHO and UNICEF field offices, relevant field projects and project staff members, and to many libraries, institutes, expert advisory panel members, regular WHO publications subscribers, journals, sales agents,

1 The legal implications of the adoption of the International Code as a recommendation were discussed in a report on the code by the Director-General to the Thirty-fourth World Health Assembly (document WHA34/1981/REC/1, Annex 3).

2 In paragraph 3 of resolution WHA34.22 the Thirty-Fourth World Health Assembly decided that "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". The Director-General's progress report on the implementation of resolution WHA33.17 (on the study of WHO's structures in the light of its functions) is submitted to the Health Assembly in document A35/13 (see Annex 8 in this volume).

infant-formula manufacturers, nongovernmental organizations, as well as to all participants in the various consultations held with interested parties during the period of the Code's development during 1980 and 1981.


80. Unofficial translations of the Code have been prepared in Dari, 2 Dutch, German, Norwegian, Portuguese, Pushtu, 2 and Swedish.

Action taken by Member States of WHO giving effect to the principles and aim of the International Code

African Region

81. The WHO Regional Office for Africa has prepared a methodology for monitoring the application of the International Code at the national level. This methodology was first tested during a workshop on infant and young child feeding held in the Congo, and was revised following the Zaire national consultation on the testing of the guiding principles 3 prepared by WHO to facilitate Member States' reporting on action taken in the field of infant and young child feeding. There are plans for six national workshops to be held both in 1982 and in 1983 as a means of supporting Member States' monitoring efforts.

82. In Botswana the promotion of breast-milk substitutes on radio or television has been prohibited. Manufacturers may meet with heads of health units, but no direct contact with mothers or health workers in peripheral centres is allowed, and the provision of samples is not permitted unless specifically requested by the Ministry of Health. Several changes made in the labelling requirements for containers were brought to the attention of manufacturers in November 1981, but pictures of mothers and infants are still used for advertising purposes.

83. The Government of Ghana is reported to be adapting the provisions of the International Code to meet national circumstances, as is the Government of the United Republic of Cameroon in conjunction with a WHO-supported nutrition project. In Guinea the importation and distribution of infant formula is a government responsibility and products can be purchased on prescription only in state-operated pharmacies. In Kenya, where import duties on infant formula were lifted in 1981, the Government adopted a national code of marketing of breast-milk substitutes in April of the same year.

84. A number of the recommendations for national action made by a workshop on breast-feeding held in Ethiopia in April 1981 concerned the marketing and distribution of breast-milk substitutes. These included the discontinuance of the distribution of samples to health workers and mothers; banning of advertising and other forms of promotion of breast-milk substitutes through the mass media; and the institution of controls on the quality and distribution of infant feeding bottles and on the provision of information concerning their appropriate use.

1 In addition, the Indian Academy of Pediatrics distributed 1000 copies of the complete version of the International Code to its members in late 1981.

2 In Afghanistan.

3 Section 2.5 of the guiding principles concerns the appropriate marketing and distribution of breast-milk substitutes. See also paragraphs 5-8 of the present report.
85. **Lesotho** has drafted a breast-milk substitutes marketing code closely resembling the International Code. The first draft was circulated immediately following Lesotho's participation in September 1980 in a consultation with selected Member States on the draft International Code. A national workshop, co-sponsored by the Ministry of Health and the Food and Nutrition Coordination Office, was held in 1981 to review the draft national code and to plan a breast-feeding promotion campaign. Also of relevance is the fact that the Government has introduced legislation providing 90 days of fully paid post-natal maternity leave for mothers working in industrial, communal or government jobs; nursing facilities at or near the work place; and special sick leave if a breast-feeding infant falls ill. The legislation makes discrimination against nursing mothers a punishable offence.

86. In **Mozambique** the Ministry of Health has established a Working Group on Infant Feeding (composed of paediatricians, nutritionists and gynaecologists) which is studying the International Code with a view to adapting it for local implementation, including the development of legislation. Although no timetable has been drawn up for implementing the Code, activities are proceeding according to needs. For example, a breast-feeding promotion campaign was undertaken in January and February 1982, with emphasis on informing health workers of the importance of breast-feeding and the dangers of the inappropriate or unnecessary use of breast-milk substitutes. The Working Group has designed a new label for breast-milk substitutes, account being taken of the provisions of the International Code in this respect. It is also drawing up policy guidelines for the importation and distribution of breast-milk substitutes. In this connexion, a contract has been signed with a single foreign manufacturer for limited importation of milk products under the supervision of national health authorities. During a week-long "health days" celebration in November 1981 the Ministry of Health distributed 200 copies of the International Code for discussion among health personnel.

87. A local code of ethics and professional standards for advertising product information and advisory services for infant formula was drafted in **Nigeria** in 1981 following meetings with representatives of all of the country's major infant-food manufacturers. The Ministry of Public Health in **Rwanda** is planning a six-day workshop on infant and young child feeding for mid-April 1982, when one of the items to be discussed will be the adoption of national legislation based on the International Code. The Government of the United Republic of Tanzania is considering the application of the principles and aim of the International Code within the context of its national food and nutrition policy. Although there are as yet no specific legislative provisions concerning the importation and distribution of breast-milk substitutes in **Togo**, the fact that such products are purchased for retail sale solely by a government concern permits some measure of control over importation and distribution.

88. During a national workshop on infant and young child feeding held in **Zaire** in October 1981 the Government emphasized the implications of the International Code for national legislation. The draft text intended to amend 1959 regulations concerning the importation and marketing of tinned milks was under discussion at this meeting; section 38 requires that all milk or milk substitutes intended for human consumption mention the superiority of breast milk. While not directly prohibited, all promotion via the mass media must first obtain clearance from the National Planning Centre for Human Nutrition.

89. The Government of **Zambia** introduced some years ago the requirement that labels on all infant formula tins bear the message "breast-feed your child", as well as a statement that "the best food for your child is mother's milk . . . better than this or any other kind of artificial food".

90. The booklet **Baby feeding: behind and towards a health model for Zimbabwe** is being distributed widely in **Zimbabwe** by the Ministries of Health, Community Development and Women's Affairs, and nongovernmental organizations. The Government is now considering what action to take to adapt the International Code to national circumstances on the basis, **inter alia**, of the recommendations contained in the booklet. These recommendations include placing feeding bottles and teats on prescription; restricting the use of infant formula in maternity wards; and ensuring that health workers are fully aware of the dangers of artificial feeding and the importance of protecting and promoting breast-feeding.
Region of the Americas

91. In Brazil surveys in 1981 in Recife and São Paulo of mothers, health professionals and health facility administrators indicated that, while mass media advertising for breast-milk substitutes no longer occurred as a result of an agreement with industry, promotion continued throughout the health care system where literature and product samples were distributed at pre-natal, child care and maternity clinics. In 1981, three draft codes of marketing of breast-milk substitutes were prepared by different parties, including the Brazilian Food Industry Association. Efforts are being made to complete work on a national code and to ensure its enactment and enforcement through appropriate legislative measures.

92. In addition to continuing the national information programme on breast-feeding launched in 1979, the federal health authorities in Canada have been promoting the application of the International Code by discontinuing the distribution of samples of infant formula in hospitals under federal jurisdiction. Provincial governments have given increasing attention to the importance of breast-feeding in recent years. For example, the Province of Quebec has adopted a policy prohibiting the distribution of infant formula samples in health facilities within its territory. The Department of Health of the Province of Newfoundland and Labrador has issued guidelines to hospital administrators for complying with the provisions of the Code, including a "no samples" policy, the removal of infant formula advertising from materials given to expectant and new mothers, and the provision to mothers of reliable health information on such topics as nutrition and infant care.

93. Some of the recommendations contained in the International Code have been incorporated into Colombia's decree\(^1\) No. 1220 of 23 May 1980 regulating the promotion, labelling and packaging of breast-milk substitutes and supplements. The decree provides that all commercial promotion of breast-milk substitutes must specifically state that breast milk is the best infant food and that the product being promoted, or any other breast-milk substitute, is harmful to the health of the infant unless the directions for preparation and hygiene are strictly followed.

94. The legal unit within the Ministry of Health of Costa Rica has examined a series of reports on possible approaches to implementing the provisions of the International Code, including a law and an executive decree. In the meantime, emphasis has been placed on a campaign to educate the public concerning the benefits of breast-feeding and the dangers of inappropriate or unnecessary artificial feeding.

95. While the Medical Division of the Ministry of Education, Youth Affairs and Sports in Dominica reports that no acute problems exist concerning the marketing of infant foods, the Government considers that it is advisable to draw up legislation which may become necessary in the future. The Government of Dominica has indicated its interest in the possibility of participating in a regional consultation on the formulation of legislation concerning the appropriate marketing and distribution of breast-milk substitutes, in collaboration with the Caribbean Food and Nutrition Institute and WHO, as have the health authorities in Grenada, Saint Vincent and the Grenadines, and the Turks and Caicos Islands.

96. The National Commission for the Promotion of Breast-feeding in Guatemala is responsible for making arrangements for the implementation of the International Code through national legislation, with final action expected later in the year. The Government of Honduras is studying the International Code with a view to adapting it to its legislative framework.

97. The Secretariat for Health and Welfare of Mexico has formed a committee which is responsible for studying the International Code and determining how it should be adapted to national legislation. This committee is expected to complete its deliberations towards mid-1982 and to present its conclusions, on the basis of which regulations may be drawn up.

98. Nicaragua has published decree No. 912\(^2\) of 15 December 1981 promulgating the Law for the promotion of breast-feeding. This Law prohibits the advertising of breast-milk substitutes,

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supplements and feeding bottles "if such advertising could induce mothers to use them in preference to breast-feeding", and requires that all labels bear the slogan "breast milk is best" in addition to precise, clear instructions regarding correct preparation and hygienic handling. Section 8 of the Law, however, entirely bans advertising of the above products via the mass media.

99. WHO provided technical support, at the request of the Government of Peru, for the review and revision of its 1980 national code of ethics for infant formulas.1 This exercise has been undertaken by a number of ministries in collaboration with interested parties, including the Peruvian Paediatric Association and representatives of the infant-food industry. It is anticipated that the revised code will come into force in 1982.

100. In Trinidad and Tobago the existing "Guidelines for professional standards in advertising, product information, and advisory services for infant formula products" require inter alia that product information for the public always include statements to the effect that breast milk is the food of choice and the recommendation to seek professional advice when an alternative may be required; and that no samples of infant formula be given to mothers by personnel employed by industry. Contact between mothercraft personnel and mothers in health care facilities is prohibited, but the former may advise or instruct the latter at the request of the mother or a health professional. Advertisements should conform to the Advertising Standard Authority's Code of Advertising Practice (1979) and to the International Council of Infant Food Industries' statement of basic marketing principles.

101. In the United States of America the Infant Formula Act of 19802 emphasized safety and nutritional standards for infant formula. It directed the Secretary of Health and Human Services to conduct a review of existing labelling requirements for such products in order to determine their effect on infant nutrition and the proper use of infant formula. The Secretary was also directed to conduct a review of issues concerning the export of infant formula which, if marketed domestically, would not meet the same requirements as are applicable in the United States. On 21 December 1981 the Food and Drug Administration proposed regulations3 that would facilitate the removal from the market of infant formulas which fail to meet the statutory requirements as to nutrient composition, or which are otherwise adulterated or misbranded within the meaning of current regulations. In November 1981 the Department of Health and Human Services formed two task forces to deal with infant formula issues: one which has been asked to produce an assessment of scientific evidence relating to problems of infant feeding, including bottle feeding and infant health, and the effects of advertising, marketing and promotion of infant formula on breast-feeding and infant health; and another which is studying "the possible applicability, or lack of it, of the WHO code's provisions" in the United States of America.

102. The United States Congress has voted US$ 5 million to be used during the fiscal year 1982 to support the efforts of developing countries to improve infant feeding practices, in particular through the promotion of breast-feeding. In using the funds the United States Agency for International Development has been directed to provide support for necessary research to obtain better information on the precise nature and magnitude of problems relating to infant feeding practices, including the use of infant formula, in developing countries. As part of the Congressional presentation documentation for the fiscal years 1983 and 1984, the President has been requested to provide information relevant to the use of these funds and a summary of reports by Member countries of WHO on their actions to implement the International Code.

103. A draft code of marketing of breast-milk substitutes for Venezuela has been prepared by the Secretariat of Public Health of the Ministry of Health and Social Welfare. Direct advertising to the public is permitted under this code's provisions, although previous governmental approval is required. Persons employed by manufacturers and distributors of breast-milk substitutes are permitted to provide advisory and educational services in institutions of the health care system if requested to do so by these same services.

104. The International Code received regional endorsement at the Conference of Ministers Responsible for Health of the Caribbean Community (CARICOM), held in July 1981 in Belize. This meeting adopted two resolutions which inter alia urged national action in support of breast-feeding and implementation of the International Code. The CARICOM Secretariat has been mandated to request WHO/PAHO and UNICEF cooperation to this end.

South-East Asia Region

105. In January 1982 the Director-General of Health Services in Bangladesh convened a meeting of responsible government officials and representatives of a nongovernmental community health research organization to discuss current infant feeding practices in the country and ways and means of applying the provisions of the International Code. The meeting recommended that a national workshop be co-sponsored by the Ministry of Health and the Bangladesh Paediatric Association, with participation from appropriate nongovernmental organizations and the infant-food industry, and support from WHO and UNICEF, in order to formulate a national strategy for the protection and promotion of breast-feeding and to make recommendations for the application of the International Code.

106. The Government of India has been holding consultations for more than a year with interested parties (health professionals, representatives of the infant-food industry, consumers' organizations and others) leading to the preparation of its own draft code. WHO and UNICEF were represented on the working group on infant and baby foods which was responsible for drafting the "Code of conduct for production and marketing of infant foods and feeding bottles in India", which is awaiting final administrative and legal approval.

107. Breast-feeding continues to be a priority health concern in Indonesia and is integrated in the basic messages for mothers found in training and educational materials. The Government is in the process of formulating a national code of marketing, with a final version expected to be adopted later in the year. WHO cooperated with the Government of Indonesia in April 1981 by providing, at the latter's request, a nutrition and a legal consultant to advise on ways and means of developing and integrating measures relating to the appropriate marketing and distribution of breast-milk substitutes into national health and legal structures.

108. Owing to their high cost and limited supply, there is relatively little use of commercially-prepared breast-milk substitutes in the Maldives. The Ministry of Health intends, however, to take steps to reinforce existing favourable breast-feeding trends and to limit the impact of increased exposure to practices in industrialized countries and the growing availability of consumer products.

109. WHO is collaborating with the Government of Nepal in drawing up a country work plan in the field of infant and young child feeding and, within this context, in initiating action for the development of a national code of marketing of breast-milk substitutes.

110. In Sri Lanka Direction 3 made under the Consumer Protection Act of 1979 requires that the container or wrapper of any milk food contain the advice "Doctors say breast-feeding is best". Direction 24 under the same Act, published in 1980, banned the advertising of "any milk food in Sri Lanka in any visual advertisement in any manner whatsoever or over the radio". In addition, the Government of Sri Lanka has developed a "Code for the promotion of breast-feeding and marketing of breast-milk substitutes and related products" which is modelled closely on the International Code. The draft has received cabinet approval and was forwarded in the latter part of 1981 to the Legal Draftsman for the preparation of appropriate national legislation. The Food and Nutrition Policy Division, which participated in the code's preparation, will be responsible for its implementation and monitoring.

111. In accordance with Thailand's Food Control Act, infant foods have been classified as a specially controlled food, and standards have been laid down for the quality control and manufacturing processes. With the cooperation of the Paediatric Association of Thailand, the "Thai code on advertising and distribution of breast-milk substitutes and related products"

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1 Membership of CARICOM: Antigua, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Montserrat, St Kitts-Nevis-Anguilla, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago.

was developed with the International Code as a guide. The Government of Thailand announced in December 1981 that its code had been adopted as an advisory measure.

European Region

112. A legal consultant, jointly funded by WHO and UNICEF, was recruited in the latter part of 1981 by the European Regional Office to participate in its programme of support to Member States for the implementation of the International Code. This Office has proposed holding a workshop in 1982 on the legal issues involved in the Code's implementation.

113. In a number of countries in the European Region the importation or local manufacture and distribution of breast-milk substitutes is a direct responsibility of the State. For example, in Algeria the Government is the sole importer and distributor of infant formula, which bears its own label in conformity with national breast-feeding promotion policy, and efforts are made to ensure that such products are made available only to those infants who require them. In Bulgaria the production of all foods for infants and children is carefully controlled by the health services. In accordance with the provisions of the International Code the Ministry of Health has been reexamining the packaging of infant foods; the instructions provided for their use and publicity; the constituents of breast-milk substitutes; and the frequency and duration of breast-feeding and health education on the subject. In Czechoslovakia the State controls the industrial production of breast-milk substitutes, and they are available to consumers only on a prescription basis. No advertising of such products is permitted.

114. In February 1981 the Government of Denmark amended its original 1971 Order on breast-milk substitutes with particular reference to labelling, including such elements as composition, minimum shelf-life, directions for storage and use, identification of the manufacturing or packaging firm, and place of product origin.

115. "The principles of fair competition in the dietetic food industry" have governed the marketing and distribution of breast-milk substitutes in the Federal Republic of Germany since their adoption by the Federal Trade Commission in 1964. Following the adoption of the International Code the German Paediatric Association and the Federal Association of Dietetic Food Industries submitted to the federal health authorities a draft joint agreement on voluntary advertising restrictions for the protection of breast-feeding.

116. In Finland and France the marketing and distribution of breast-milk substitutes have also been governed by voluntary agreements between industry and the competent national authorities. In France nine producers and distributors of infant formula have agreed to recommendations formulated by the Committee on Nutrition of the French Paediatric Society in 1979.

117. Industrially manufactured breast-milk substitutes are available in Hungary on a prescription basis only. Since the adoption of the International Code the Ministry of Health has held discussions with the single national manufacturer of infant formula with a view to instituting a total ban on the advertising and promotion of its products to the general public.

118. Monitoring and reporting on action taken to give effect to the principles and aim of the International Code in the Netherlands is the responsibility of an interdisciplinary ad hoc working group established by the Ministry of Health and Environmental Affairs. There is no advertising of infant formula in the country at present, and the Government is urging manufacturers to avoid providing samples of infant formula, as well as gifts in general, to young or expectant mothers. It is also urging manufacturers and exporters of infant formula to abide by the Code's provisions concerning advertising or other forms of promotion. Copies of the International Code are being distributed to health workers whose responsibilities include maternal and child care.

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119. Specific adaptations concerning labelling regulations for the Netherlands are planned in the light of the Code's provisions in this respect. The Government has reserved its position as regards pictures of infants on labels, insisting that it is important to differentiate clearly between appropriate and unsuitable products for infant feeding; it has suggested that a possible solution may be the use of an internationally adopted graphic symbol. It does not allow instructions on any label for the modification of a product into infant formula.

120. The Directorate of Health in Norway has recently entered into discussions with industry representatives in order to reach a voluntary agreement on marketing restrictions based on the provisions of the International Code. In addition, a code on the quality of infant formula and supplementary foods, based on Codex Alimentarius standards, will be drawn up. The Directorate of Health has recommended to maternal and child health centres that samples of infant foods should not be distributed.

121. As early as 1964 a document entitled "Medical standards for marketing of infant foods" was prepared in Sweden by a group of paediatricians and others as a guide for the infant-food industry. Among its main provisions, the document recommended against the advertising of breast-milk substitutes to the public or families, special discount offers, the advertising of other infant foods to consumers before infants reach three months of age, and the free distribution of infant foods and similar promotional measures. A number of slight revisions were introduced in 1975, and the most recent version dates from November 1981.

122. In 1978 the National Board of Health and Welfare in Sweden issued instructions on the desirability of avoiding the use of breast-milk substitutes during the first week of life; hospital maternity departments were asked to ensure that, as far as possible, neonates receive breast milk, and it was recommended that large maternity departments provide a nurse-midwife to instruct mothers and health personnel on breast-feeding and to supervise the collection of breast milk.

123. The Government of Switzerland has been holding consultations with health professionals and representatives of the infant-food industry with a view to formulating guidelines for the marketing and distribution of breast-milk substitutes.

124. The preparation of an amendment to the regulations governing foodstuffs began in Turkey in 1981; the proposed amendment includes a number of sections dealing with the quality and marketing of infant foods. The draft provisions stipulate that breast-milk substitutes may not be advertised via the mass media and ban the distribution of samples, with the exception of those provided to doctors and health organizations engaged in research. All packages and related product information are to bear the reminder that breast milk is the most suitable nutrient in the first months of life, that it is superior to any substitute, and that it meets all of an infant's nutritional needs during the first four months of life. The provisions concerning mass media advertising were adopted in early 1982.

125. In the United Kingdom of Great Britain and Northern Ireland it is the Government's intention to give effect to the principles and aim of the International Code through the encouragement of industry self-regulation. To this end discussions on the Code's implementation are being held with the Food Manufacturers' Federation, and the Government also anticipates holding consultations with representatives of the health professions, consumer organizations and other interested groups.

European Economic Community

126. In addition to the various steps being taken unilaterally by Member States in the European Region to give effect to the principles and aim of the Code, the European Parliament has called for collective action to be taken in this respect by members of the European

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2 Belgium; Denmark; France; Germany, Federal Republic of; Greece; Ireland; Italy; Luxembourg; Netherlands; United Kingdom of Great Britain and Northern Ireland.
Economic Community on the basis of a resolution it adopted on 15 October 1981.\(^1\) This resolution had its origins in the activities of the Parliament's Committee on Development and Cooperation which, since January 1980, had been considering the implications of the export and sale of infant foods from the Community to developing countries.

127. The European Parliament's resolution endorsed the International Code, welcomed the constructive role played by Member States of the Community in its elaboration, and expressed satisfaction at the commitment undertaken on behalf of the Community and its Member States, at the Health Assembly, to support the Code and to take the necessary steps for ensuring its application. The Parliament called on the Commission of the European Communities to submit urgently to the Council proposals for a Directive to ensure uniform application of the Code; called on the Community and national authorities to take whatever steps were needed to ensure respect for the relevant provisions of the Code as regards breast-milk substitutes exported from the Community; and recommended that the EEC/ACP\(^2\) Joint Committee examine whether any possibility existed for mutual assistance and cooperation between EEC States and the ACP countries in this area, in particular as regards drafting of appropriate legislation for the application of the Code, and monitoring promotional and sales activities. Finally, the Parliament called on the Commission to report annually to it about the application of and respect for the International Code both within the Community and by Community-based firms operating in the rest of the world, and about the situation regarding breast-feeding and the use of breast-milk substitutes in Member States.

Council of Europe

128. Just prior to the adoption of the International Code by the Health Assembly, a group of 18 parliamentarians of the Council of Europe's Parliamentary Assembly, meeting in Strasbourg from 11 to 15 May 1981, tabled a written declaration on the then-draft Code.\(^3\) This action resulted from an initiative taken by the Committee on Social and Health Questions during its meeting in Paris on 27 April 1981.

129. The written declaration emphasized that, where conditions of storage and sterilization were inadequate and families were often unable to understand instructions on packages, breast-milk substitutes could contribute to major malnutrition problems and morbidity; and that a worldwide campaign should be launched to encourage information and education of parents on the beneficial effects of breast-feeding and to limit and control the promotion and sale of substitute products. The declaration welcomed the Code initiative taken by WHO in cooperation with UNICEF and other specialized bodies of the United Nations, and called on governments of member States of the Council of Europe to give their full support for its rapid adoption as a binding regulation.

Eastern Mediterranean Region

130. During a national seminar on the child and the law organized in Afghanistan by the Ministry of Justice, the International Code and the draft national codes of India and Sri Lanka were reviewed. Among the recommendations made concerning the legal aspects of infant and young child feeding were that the Government should formulate its own code of marketing of breast-milk substitutes in accordance with the principles and aim of the International Code; that the import, production and sale of breast-milk substitutes should be regulated in a manner so as to encourage breast-feeding; and that the import, production and sale of pacifiers (dummies) should be prohibited.

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\(^1\) The resolution was adopted by 124 votes in favour to 14 against, with 25 abstentions. For text, see Official Journal of the European Communities, No. C 287, 9 November 1981, pp. 75-77.

\(^2\) European Economic Community/African, Caribbean and Pacific countries that are signatories to the Lomé Convention.

131. In Democratic Yemen no advertising whatsoever for breast-milk substitutes is permitted. The Government imports a number of breast-milk substitutes which are provided on a state-subsidized basis to infants who require them.

132. In Egypt Ministry of Health Decision No. 514 (1980) prohibited the display or general distribution of infant foods and breast-milk substitutes or supplements in maternity and other health units; the advertising of breast-milk substitutes by public media; and the importation of breast-milk substitutes except through official channels. Such substitutes are distributed free of charge in maternal and child health units to children who need them, and the method of preparation is demonstrated in educational kitchens in the same health units.

133. The Government of Israel has announced that the Ministry of Health has decided to adopt the International Code and to translate it into suitable measures for the purpose of implementation.

134. The Pakistan Paediatric Association's Committee on the Code of Ethics has drawn up a draft "Code of marketing in Pakistan for infant formula and other products intended for use as breast-milk substitutes". This draft code was unanimously endorsed by the Sixth Biennial Paediatrics Conference in February 1982 and forwarded to the Ministry of Health for formal action by the competent authorities at the national level.

135. Although breast-feeding remains the predominant infant feeding mode in Sudan, recent surveys show that the sale of breast-milk substitutes is rapidly increasing. Such control as existed in the marketing of infant formula lapsed in 1973, when breast-milk substitutes were reclassified as "foodstuffs", rather than "drugs". The Sudanese Paediatric Association voiced its concern in 1981 about the increase in artificial feeding. Steps are now planned by the Ministry of Health to promote breast-feeding and to introduce a marketing code.

136. In the Syrian Arab Republic the Ministry of Health set up a committee, headed by the Vice-Minister of Health, to study the International Code and to prepare recommendations to the various national authorities concerned with a view to implementing the Health Assembly's resolution in this respect. The committee's recommendations have been reported to and approved by the responsible national authorities; laws and recommendations will be formulated to implement the relevant portions as appropriate to national circumstances.

137. Since its adoption the International Code has been under review in Tunisia by the National Commission for the Promotion of Neonatal and Infant Feeding with a view to adapting its provisions to the national context. In addition to the various measures that have been taken to encourage and protect breast-feeding on the basis of the Commission's recommendations, the Ministry of Public Health has issued a circular letter (No. 168/81 of 18 August 1981) to regional health directors concerning the discontinuance of all advertising for breast-milk substitutes in all facilities under the Ministry's jurisdiction, and of the provision of samples of breast-milk substitutes to medical and paramedical personnel and to families. Since January 1982 a subcommittee of the Commission has been formulating a draft code based on the International Code and in keeping with national needs and circumstances.

138. In Yemen the Ministry of Health took a number of steps in June 1981 to give effect to the principles and aim of the International Code. Yemeni television and radio, for example, ceased broadcasting advertisements for various forms of breast-milk substitutes, and all advertising and promotion of breast-milk substitutes in health care centres was suspended. In addition, Yemeni television, assisted by a paediatrician and other health personnel, has initiated a campaign to increase awareness among the general public of the advantages of breast milk and the disadvantages of breast-milk substitutes. Finally, the Ministry of Health has formed a committee which includes WHO experts in the field of primary health care to formulate proposals concerning the marketing of breast-milk substitutes.

Western Pacific Region

139. The Government of Australia is taking steps to implement resolution WHA34.22; for example, the Department of Health has held talks with industry representatives on voluntary self-regulation of advertising. The National Health and Medical Research Council has set up a working party on standards for infant foods and related standards for labelling.
140. In China the Ministry of Light Industry convened a meeting on dairy products and children's food. Criteria for breast-milk substitutes and weaning food were formulated, analytical methods standardized, and issues relating to the use of beans and fish powder as raw materials and their production and marketing discussed.

141. The Government reports that there is no advertising or other form of promotion of breast-milk substitutes or weaning foods in the Cook Islands, and a mass media campaign to promote breast-feeding has been under way since July 1981. Nurses are required to include in their monthly job reports information on their efforts to encourage and support breast-feeding.

142. Malaysia has had a national code since 1979, the "Code of ethics and professional standards for advertising, product information and advisory services for infant formula products". The "Code of ethics on the sale of infant formula products" was adopted in Singapore in November of the same year. A subcommittee of the Sale of Infant Formula Ethics Committee, consisting of representatives of the Ministries of Health and Environment and the Singapore Breast-feeding Mothers' Group, monitors the activities of commercial firms in this respect.

143. The Government of New Zealand has met with representatives of local manufacturers of breast-milk substitutes, with the result that manufacturers have agreed to cooperate in producing a document setting out what steps they will take to ensure that the provisions of the International Code are observed as far as is practicable. In addition, a meeting to discuss implementation of the Code in New Zealand was held between the Departments of Health, Agriculture and Fisheries, and Industry, and the New Zealand Dairy Board. Hospital boards and district health offices have been informed of the recommendations of the WHO/UNICEF Meeting on Infant and Young Child Feeding and of the adoption of the International Code.

144. The Government of Papua New Guinea adopted in 1977 the Baby Feed Supplies (Control) Act which provides that baby bottles, bottle teats, and dummies are prescribed articles, for sale only under prescription by an authorized health worker who has first satisfied himself or herself 'that it would be in the interest of the baby or infant . . .'; who "also gives the prescribed instructions . . ."; and who is "satisfied that the person receiving the instructions understands them". The Act prescribes any advertising "the intention or likely result of which is to encourage: (a) the bottle-feeding of babies; or (b) the purchase or use of prescribed articles; or (c) the purchase or use of milk or other products in connection with prescribed articles".

145. WHO collaborated with the Government of the Philippines during its national consultation held in December 1981 for the development of a national code of marketing of breast-milk substitutes. The draft code is being reviewed by the Ministry of Health before its submission to the competent authorities for adoption as national legislation.

146. The Government of the Solomon Islands is forming a national nutrition committee to define goals and identify target groups and main lines of action. It has expressed an interest in developing national legislation to limit the promotion and sale of breast-milk substitutes and weaning foods.

147. The Agriculture Department in Samoa has recently developed an infant formula with a high local-food content. While in the past some inappropriate marketing techniques have been used, more recent collaboration between infant-food manufacturers and the Government has been reported to be adequate. The Health Department favours the preparation of national legislation to give effect to the principles and aim of the International Code.

148. A working committee on nutrition is being constituted in Tonga with infant and young child feeding as its principal focus. Since 1979 advertisements for infant formula have been voluntarily cleared with the Ministry of Health.

149. Representatives of nine countries and territories (Cook Islands, Fiji, Kiribati, Papua New Guinea, Solomon Islands, Tonga, Tuvalu, Vanuatu, and Samoa) met during the

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First South Pacific Regional Maternal and Infant Nutrition Seminar in Suva, Fiji, from 11 to 15 May 1981. This seminar adopted a resolution which *inter alia* urged the governments of all Pacific nations to give the fullest possible support to the protection and promotion of breast-feeding and to adopt the International Code.

Collaboration with the Codex Alimentarius Commission

150. In the process of preparing the International Code, the work done by the Joint FAO/WHO Food Standards Programme and its Codex Alimentarius Commission, among other organizations and bodies of the United Nations system, was carefully taken into consideration. The Codex Alimentarius Commission, in turn, followed closely the development of the International Code and the possible implications for its work arising from its various provisions.

151. At the request of the Executive Committee of the Codex Alimentarius Commission, the International Code was placed before the Commission at the latter's fourteenth session (Geneva, June-July 1981). The Commission's attention was drawn to paragraph 4 of resolution WHA34.22, whereby the Assembly had requested "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". Following its deliberations the Commission concluded that, whereas the Committee on Foods for Special Dietary Uses had indeed developed comprehensive standards to safeguard the quality of these products, it would be appropriate to review the sections dealing with labelling, advertising and instructions for use, having regard to the relevant articles of the International Code. In the first instance this work would be carried out by the Committee on Foods for Special Dietary Uses. Subsequently the Codex Committee on Food Labelling would exercise its endorsement function. Further matters for consideration by the Codex Committee on Foods for Special Dietary Uses might relate to the nutritional value of the products and, especially, effects of storage time and conditions on their nutritional value (see paragraph 157).

152. Two items on the draft agenda of the twenty-ninth session of the Codex Executive Committee (Geneva, 12-16 July 1982) are of interest in the present context: item 4 - report on the developments concerning the International Code of Marketing of Breast-milk Substitutes; and item 5 - consideration of a reference to the International Code in the Code of Ethics for International Trade in Food (CAC/RCP 20-1979).

Collaboration with the Commonwealth Secretariat

153. Members of the WHO and UNICEF secretariats met in London in January 1982 with representatives of the Legal, Medical, and Women and Development Divisions of the Commonwealth Secretariat, at the latter's invitation, to discuss possible collaboration with respect to the implementation of the International Code. The Commonwealth Secretariat's Legal Division is initiating the drafting of model legislation to implement the Code for dissemination to all Commonwealth countries, and seeks the collaboration of WHO and UNICEF in this and related matters. Possibilities for future cooperation include the co-sponsorship of a workshop whose purpose would be to define strategies and identify mechanisms for implementing the Code.

The development of country case studies

154. Although the origins of and major steps leading to the development of the International Code by WHO and UNICEF are by now well known, the experiences of individual Member States in giving effect to its principles and aim are much less familiar. Since such experiences constitute a valuable source of comparative information of possible benefit to Member States collectively, it has been decided to prepare a number of brief but detailed country case studies for general distribution. As a first step, three countries (Colombia, Mozambique and Peru) have been identified for this purpose, and information gathering and report writing are under way.

1 Thirty-six of which are Member States of WHO.
Informal consultation on feeding bottles and teats

155. A preliminary informal consultation was organized jointly by WHO and UNICEF in June 1981 on the subject of feeding bottles and teats. The purpose of this consultation was to facilitate an exchange of views among interested parties on the overall health implications for infants and young children of the use of these devices; the dangers to health which may be inherent in the use of inferior quality products; and the particular information, education and labelling requirements for these products where appropriate use by, and marketing to, the general public are concerned. Participants in this consultation included representatives of WHO and UNICEF, the International Organization for Standardization (ISO), and seven bottle and teat manufacturers from the Federal Republic of Germany, India, Italy, Japan, and the United Kingdom of Great Britain and Northern Ireland.

156. On a related issue, following studies undertaken in the Federal Republic of Germany and Japan on the occurrence of volatile N-nitrosamines in certain rubber products used by infants, including teats and dummies, the two Governments are considering the imposition of controls on rubber articles to limit infant exposure to these known carcinogens. The United States Food and Drug Administration has also expressed its concern to rubber manufacturers and other interested parties in a letter (February 1982) soliciting information on the subject, in particular as to why nitrosamines occur in these products, and whether alternative manufacturing procedures could eliminate or reduce the problem.

VII. NUTRITIONAL VALUE AND SAFETY OF PRODUCTS SPECIFICALLY INTENDED FOR INFANT AND YOUNG CHILD FEEDING

157. The Thirty-third World Health Assembly, in paragraph 5(1) of its resolution WHA33.32, requested the Director-General "to cooperate with Member States on request in supervising or arranging for the supervision of the quality of infant foods during their production in the country concerned, as well as during their importation and marketing". Further, the Thirty-fourth World Health Assembly, in its resolution WHA34.23 on the nutritional value and safety of products specifically intended for infant and young child feeding, requested the Director-General inter alia "to initiate studies to assess the changes that occur ... under various climatic conditions ... 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".

158. As one step in implementing these resolutions, a preliminary informal consultation was held in Geneva from 26 to 28 October 1981 with experts in nutrition, microbiology, food packaging and toxicology. Participants were invited to review existing information concerning the effects of storage on the nutritional value, microbiology and residues of breast-milk substitutes and supplementary foods for infant and young child feeding; identify sources of information on the subject that are not readily accessible but might be made available on request; and develop a protocol for the planned study on the effects of storage and usual distribution channels on the nutritional value, microbiology and residues of the products in question. The Director-General will report in 1983 to the Thirty-sixth World Health Assembly on progress achieved in giving effect to resolution WHA34.23.

159. In this connexion, WHO is providing financial support for a meeting of some 20 nutritionists to be held in Varna, Bulgaria, from 5 to 8 April 1982, jointly organized by the International Medical Association for the Study of Living Conditions and Health and the International Organization of Human Ecology. The first item on this meeting's agenda - baby foods: safety and nutritional value - is of particular relevance to WHO's infant and young child feeding programme, and attention will be drawn to resolution WHA34.23.

VIII. LEGISLATION IN RELATION TO INFANT AND YOUNG CHILD FEEDING

160. WHO continues to monitor and review legislation in different countries for enabling and supporting breast-feeding, especially by working mothers, in compliance with paragraph 6(6) of

1 Feeding bottles and teats are included within the scope of the International Code, under Article 2.
resolution WHA33.32. During the past year recent texts of items of direct or indirect relevance to this question were published in the WHO International Digest of Health Legislation concerning Ethiopia, the Federal Republic of Germany, Hong Kong, Iraq, Luxembourg, New Zealand, Portugal, and the United Kingdom of Great Britain and Northern Ireland.

161. The Perinatal Study Group in the European Regional Office has completed a survey of maternity protection legislation in the 35 countries of the European Region.

162. Early in 1981 WHO produced an offset document entitled "Foods for infants and young children: a survey of relevant national legislation". This survey was made available to Member States and other interested parties through the regional offices. WHO has also provided to FAO relevant materials for, and commented in detail upon, a draft expanded study on this same theme that is being prepared on behalf of FAO's Legislation Branch.

163. In conformity with operative paragraph 5(2) of resolution WHA33.32 concerning the promotion and support of the exchange of information on laws, regulations, and other measures concerning the marketing of breast-milk substitutes, WHO continues to collect and analyse relevant national texts, the majority of which remain to be adopted officially. Those which have been formally published during the reporting period in Colombia, Nicaragua, Sri Lanka, and the United States of America, in particular, have been covered in the International Digest of Health Legislation. Additional texts will be covered as and when they become available.

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164. As evidenced by the numerous references above, cooperation between WHO and UNICEF in the field of infant and young child feeding continued throughout the reporting period at global, regional and country levels. WHO and UNICEF have developed a joint nutrition programme for the period 1982-1986, and infant and young child feeding is considered as an important part of nutrition in primary health care. The programme emphasizes the protection and promotion of breast-feeding and appropriate and timely weaning practices, support for family food production, family and community food conservation and appropriate village technology.

165. As in the previous reporting period, the programme in the five main areas described above has been funded mainly by the Director-General's and Regional Directors' Development Programmes, UNFPA, UNICEF, the Swedish International Development Authority/Swedish Agency for Research Cooperation (SIDA/SAREC), and the Belgian Government. Additional funds are being sought to continue and expand these activities.

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1 Document HLE/FHE/81.1, available in English only.
2 See the footnotes to section VI of this report for specific references to these and other published texts.
ANNEX 6

ACTION PROGRAMME ON ESSENTIAL DRUGS\(^1\)

\[^{A35/7 - 1 April 1982}\]

Report by the Executive Board Ad Hoc Committee on Drug Policies
on behalf of the Executive Board

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I. INTRODUCTION

1. The idea of essential drugs, conceived in WHO during the past few years, forms one of the basic components of primary health care, the key to attaining health for all by the year 2000. Moreover, the availability of essential drugs for local health care is one of the indicators of the success of the Global Strategy for attaining this goal.

2. A WHO expert committee established model lists of essential drugs covering most health needs. Statements made in the World Health Assembly, or published in WHO publications, pointed to the existence of potent drugs capable of preventing, curing or alleviating a large number of human ailments. These same statements, however, pointed to the unacceptable state of affairs whereby these drugs are scarcely accessible to the vast majority of the world's people. These people live in the developing countries, and the main factors preventing them from having access to the drugs they require are the lack of well-defined national drug policies, inadequate distribution and supply systems both inside and outside the health infrastructure, shortage of technical and managerial expertise, lack of money at the individual level, and lack of hard currency at the government level to purchase from abroad.

3. To these must be added limited understanding and false ideas, among both health workers and the public at large, about the need for and proper use of different kinds of drugs. The prevalence of such ideas stems from inadequate exposure to objective information on the

\(^1\) See resolution WHA35.27.
preventive and therapeutic indications as well as the side-effects of drugs. Information provided on drugs varies widely in different countries: in some countries there is a lack of information; in others there is an excess of misinformation which is not adequately counterbalanced by objective information.

4. The existence of potent drugs for a wide variety of health problems is the outcome of the outstanding scientific and technological advances that have taken place over the past half century and in particular over the past three decades. In addition to the achievements of individual scientists in research institutions, major credit for this drug development must go to the pharmaceutical industry. However, this industry has not paid the same attention to ensuring the availability of the products of its research and know-how to the underprivileged of the world. Indeed, it could even claim that this is not part of its responsibilities. Yet there are signs that the industry is becoming increasingly aware of the adverse consequences of the situation whereby the underprivileged, who make up numerically the vast majority of the world’s population, are unable to enjoy the fruits of pharmacological and pharmaceutical research. Following such widespread acclaim of the goal of health for all by the year 2000 and of the strategy for attaining it, no individual or group conscience can remain untouched by this situation.

5. It is against this background that WHO’s action programme on essential drugs was launched. Resolutions EB61.R17, EB63.R20, WHA31.32 and WHA32.41 in particular laid the basis for establishing the programme, although from its inception WHO has been given a constitutional mandate in the field of drugs.

6. In this context it may be recalled that in 1981 the UNICEF/WHO Joint Committee on Health Policy adopted a joint WHO/UNICEF programme for support to the provision of essential drugs for primary health care in developing countries. This joint programme is the basis for UNICEF’s active cooperation in the plan of action set out in this document.

II. PROGRESS REPORT AND SITUATION ANALYSIS

7. The action programme on essential drugs was formally set up in February 1981, in compliance with the decision of the Thirty-second World Health Assembly. Both before and since then much activity has taken place throughout the world aimed at improving the availability and utilization of drugs at the lowest possible cost, particularly for primary health care. Emphasis has been laid on the formulation and implementation of national drug policies, more rational use of drugs, drug quality, maximizing the use of limited manpower and financial resources, and ensuring the availability of the least expensive and most effective drugs of acceptable quality.

8. The Appendix contains a detailed account of activities that have been undertaken in the WHO regions and at the global level since the programme was established. Progress, although modest, has been achieved, even in the least developed countries. A few countries have formulated national drug policies. More than 70 countries have developed lists of essential drugs for the public sector, based on the WHO model list. This could be a useful start to the development of broader national drug policies. Some countries have made progress not only nationally but also in their relationships with external suppliers of drugs. They are considering the development of national drug policies and programmes and are taking measures to provide objective information and dispel misinformation about drugs.

9. Cooperation has taken place between WHO and many Member States in the field of selection of essential drugs; quantification of drug needs; development of national distribution systems, including storage facilities and logistic support; efforts at quality assurance, drug legislation and regulatory control; early feasibility studies for the establishment of formulation plant; and manpower development. Cooperation has also taken place between a number of developing countries and bilateral and multilateral agencies, sometimes supported by regional and world banks, in such areas as setting up local formulation plant, providing equipment and paying for experts, WHO often having played a catalytic role.

10. More than 30 country studies have been undertaken at the request of the Member States concerned, with a view to analysing the drug supply situation and drug policy and management. The studies were carried out jointly by national experts and by WHO staff in the countries and regional offices concerned and from headquarters; in four countries experts from pharmaceutical companies participated. A full account of the lessons learned from these country studies appears as a part of the Appendix. These lessons have been applied in the plan of action that appears below.

11. Financial support to the programme has been encouraging. For example, France has contributed directly to WHO for the programme. The following bodies and institutions have so far supported the programme at country level: UNDP, UNICEF, the World Bank, the Asian Development Bank, and the Inter-American Development Bank. Of the donor countries, Belgium, Denmark, France, the Federal Republic of Germany, Italy, Japan, the Netherlands, Norway, Sweden, Switzerland, and the United States of America have supported one or more countries.

12. In spite of this progress many problems remain. For example, pool procurement by groups of countries has not yet got under way, although it is being considered in three WHO regions (Africa, the Americas and the Western Pacific). The lack of progress results from the complexity of the process, including difficulties in the establishment of appropriate legal and commercial agreements among countries and administrative and financial mechanisms.

13. The shortage of pharmacists, allied health professionals and other technical staff, particularly at the primary health care and immediate referral levels, hampers the formulation and implementation of programmes for essential drugs. Training programmes in the development and implementation of drug policies, drug distribution and supply and pharmaceutical technology are inadequate. In many developing countries medicinal plants are widely employed, particularly in primary health care. However, inadequate information concerning their efficacy and safety impedes better use being made of them. Efforts are being made to supply such information through WHO collaborating centres in traditional medicine.

14. Many developing countries lack the technical expertise, facilities, equipment and legislative bases needed to ensure the quality of drugs as purchased. The WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce, though accepted by 71 countries, is being inadequately utilized. Even when it is used, it does not of itself guarantee quality of drugs in use, since conditions of storage and distribution vary among countries and hence the preservation of quality cannot be adequately guaranteed.

15. In addition to complex technical considerations, political, social and commercial factors influence drug policies and their implementation. Thus, the health sector has a low priority in many developing and developed countries where health expenditure represents a small fraction of the gross domestic product. In spite of attempts by Member States to devote more to health, growing economic problems and competing domestic demands often result in governments being unable to put more resources into health care. Drug requirements are therefore correspondingly inadequately met. In addition, even if resources are allocated for purposes of public expenditure in the health field, a large proportion of this expenditure may be diverted to prestigious projects primarily located in capital cities or large towns which cater to only a small proportion of the population. Even within urban areas there is an uneven availability and use of drugs; urban and peri-urban slum dwellers receive less than the drugs they require. Therefore, in spite of commendable aspirations, in many developing countries it is usually only a minority that benefits from available drugs. On a global scale, three-quarters of the world's population, concentrated in developing countries, use only about 15% of the world drug production.

16. In spite of the principles of essential drugs and the use of generic names being part of the action programme, many physicians regard the concept of essential drugs as being too restrictive; and, accustomed to trade names, they do not find it easy or desirable to accustom themselves to generic names, since they consider brand names to be a guarantee of

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quality. Many believe generic prescribing of essential drugs is not only an infringement of their moral duty towards their patients, but also a denial of a fundamental professional right to select the drugs which they consider best suited to the needs of their patients.

17. As for the commercial factors, the structure of the pharmaceutical industry is complex. This industry is one of the most successful high-technology sectors of the world’s economy. The demand for pharmaceuticals is large and growing. Indeed, the growth rate in the pharmaceutical industry far exceeds the growth rate of the gross domestic product of many countries. Only a few developing countries have a reasonably well-developed pharmaceutical industry, but even in them many of these companies are subsidiaries of transnational corporations.

18. Patent rights for most essential drugs have come to an end, although some manufacturing processes may still enjoy such rights. Essential drugs are in general less profitable, especially in the small amounts ordered until now by many small developing countries. There has been little commercial incentive so far for the multinational companies to set up production or formulation facilities to manufacture essential drugs in developing countries. The main world supply problem, however, is not potential lack of products, but drug availability at prices that developing countries can afford.

19. Recently new developments have taken place following the declaration before the WHO Executive Board in January 1982 by the International Federation of Pharmaceutical Manufacturers Associations (IFPMA) that the pharmaceutical firms it represents are ready to supply essential drugs for the underserved populations in the developing countries under favourable conditions, and to assist in other aspects of the essential drugs programme. Agreement in principle has been reached between WHO and IFPMA to start with a few pilot countries with the intention of increasing the number progressively as experience is gained, and to cooperate with them in ensuring essential drugs for the public non-profit-making sector under favourable conditions. Such cooperation will include development of a national drug policy, selection of the drugs most needed for primary health care and the immediate referral level, estimation of the quantities required, setting up of an efficient drug distribution system, and related training. On the basis of this WHO and the countries concerned will study the financial implications and search for the most appropriate ways of financing. Subsequently, it was agreed between the Director-General of WHO and the Executive Director of UNICEF that UNICEF would become a partner in this joint effort. Also, discussions have taken place with a number of national industries, such as those of China, Hungary, India and the USSR, in relation to offers to supply essential drugs under favourable terms to the developing countries. Further details of the above will be provided in an additional annex to be distributed at the Thirty-fifth World Health Assembly.2

III. PRINCIPLES

20. It is in the above context that the following principles will guide the action programme on essential drugs in the coming years.

21. The action programme is a worldwide collaborative programme of Member States, WHO, UNICEF, other organizations of the United Nations system, the pharmaceutical industry and other institutions, both public and private. Its objective is to ensure the regular supply to all people of safe and effective drugs of acceptable quality at lowest possible cost, in order to reach the overall objective of health for all by the year 2000 through health systems based on primary health care.

22. This objective will be accomplished through programmes which are designed to meet the needs of countries on an individual basis, and which emphasize the development and strengthening of national capabilities and infrastructures towards achievement of greater self-reliance in the pharmaceutical sector through national endeavours and intercountry cooperation.

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1 See document EB69/1982/REC/2, pp. 118-119.
2 This annex did not appear; see document WHA35/1982/REC/3, summary record of the fourth meeting of Committee A.
23. The programme will aim at promoting the action required in and by Member States. WHO will provide worldwide leadership and coordination for the programme, in order to arouse adequate enthusiasm for it and commitment to participate in it. It will ensure the availability of the necessary expertise and will cooperate with Member States on request in applying this expertise in the countries concerned. In fulfilment of this role, WHO will work closely with national governments, other organizations of the United Nations system and in particular UNICEF, nongovernmental organizations, bilateral agencies, and other institutions, including the pharmaceutical industry.

24. The programme will encompass all countries that so desire, but WHO will give priority attention, in terms of both its own resources and those derived from extrabudgetary sources, to developing countries. The programme will be financed from multiple sources—countries themselves and bilateral, multilateral and financial institutions. WHO's regular budget at country, regional and global levels will be used to promote the most effective use of these resources in support of country activities.

IV. MAIN LINES OF ACTION

25. The following are the main lines of action of the programme over the coming years.

Development of national drug policies as part of comprehensive health policies

26. The development of national drug policies by all Member States is a major objective of the programme. These policies should form part of broader health policies for attaining the goal of health for all by the year 2000 based on primary health care, and should be realizable within the limits of the resources mobilized for their implementation. National drug policies should therefore relate to health systems based on primary health care, should be consistent with the concept of essential drugs, and whenever possible should emphasize preventive health care.

27. The following are the major components that have to be taken into account when formulating a national drug policy:

(i) identifying therapeutic needs;

(ii) selecting essential drugs for the different levels of the health care system and in particular for primary health care;

(iii) estimating quantities needed for the various drugs;

(iv) improving the drug supply system, including procurement, storage, distribution and logistic support and related training of personnel. Consideration could be given to pool procurement in order to benefit from the economies of scale. The system should form part of the general health infrastructure;

(v) ensuring the proper use of essential drugs through the provision of appropriate information and training for prescribers at various levels of expertise and particularly for nonprofessional primary health care workers. Where applicable, this could include information and training on the proper use of medicinal plants;

(vi) providing information and education for health workers and the general public concerning the proper use of drugs;

(vii) setting up and strengthening local formulation of certain essential drugs whenever this proves to be technically and economically feasible and desirable;

(viii) local production only when this proves to be technically and economically feasible and desirable;

(ix) ensuring quality control by means that are most appropriate for the country concerned;
monitoring adverse reactions as an integral part of the health care delivery system;

introducing appropriate legislation as necessary in such areas as drug registration; proprietary and generic names; control of information concerning therapeutic indications, contra-indications and side-effects; ethical standards relating to drugs of proven efficacy and safety and acceptable quality; quality assurance; the legal authorization of different categories of health workers to prescribe and/or administer various kinds of drugs, including injectables; price regulation and the like;

ensuring manpower requirements through the development of adequate numbers of manpower of all levels and categories who are able to conceive and implement national drug policies according to the concept of essential drugs and to undertake any intercountry activities that are needed;

ensuring coordinated multisectoral action by all sectors involved, such as health, education, planning, finance, industry, trade, and communications;

introducing an evaluation process to assess the progress of implementation and ultimate effectiveness of the national drug policy.

Intercountry cooperation

28. Intercountry cooperation is also a major feature of the programme. Such cooperation may take place between developed and developing countries as well as among developing countries. The following areas are particularly relevant for such cooperation:

(i) pool procurement by a group of countries through TCDC. Since this is a complex process, it will require careful development; prerequisites for success include full support by the governments concerned;

(ii) training and manpower development, including on-the-spot training;

(iii) quality assurance;

(iv) exchange of information on a wide variety of subjects, including country progress reports, reports on adverse reactions, market recalls, registration status, and drug prices and availability.

Action by WHO

29. WHO will have two major mutually supporting roles, namely a coordinating role and a technical cooperation role.

30. In fulfilment of its role as coordinating authority on international health work the Organization will:

(i) ensure the availability of objective information on the world drug situation, including as far as possible information on suppliers, current prices and price trends concerning drugs and raw materials;

(ii) develop international policies in its governing bodies;

(iii) formulate international programmes and plans of action for their implementation;

(iv) bring together in various combinations as necessary all concerned parties, including developing and developed countries, nongovernmental organizations, other organizations in the United Nations system, bilateral agencies, the pharmaceutical industry, experts in the different fields involved, and academic and research institutions;
(v) disseminate objective information on therapeutic indications and side-effects of drugs that can be used at the various levels of the health system and by different categories of health workers;

(vi) provide guidelines for formulating national drug policies, based on the concept of primary health care and essential drugs; for estimating and quantifying needs for various types of pharmaceuticals; for planning and operating procurement systems; and for planning and operating drug storage and distribution systems.

(vii) foster collaboration with United Nations and nongovernmental organizations concerned. Such collaboration will take place with UNICEF and other organizations of the United Nations system as well as with nongovernmental organizations concerned, with a view to ensuring the availability of essential drugs for primary health care in developing countries under the most favourable conditions. Collaboration with UNIDO, UNICEF, UNCTAD and nongovernmental organizations concerned will take place to ensure the availability of information on prices and sources of supply, including raw materials and packaging, particularly for essential drugs. Strategies will be developed for bringing about reductions in the price of essential drugs of acceptable quality for developing countries in conformity with resolution WHA31.32;

(viii) facilitate negotiations between developing countries and the pharmaceutical industry to obtain essential drugs of acceptable quality for the underserved populations of these countries on highly favourable terms;

(ix) promote international collaborative research on drug development, distribution and proper use.

31. In fulfilment of its technical cooperation role, WHO will cooperate with countries on request in the following areas:

(i) developing and implementing national drug policies in all the areas mentioned above under that heading;

(ii) supporting manpower development in collaboration with Member States, nongovernmental organizations and the pharmaceutical industry, through support to on-the-spot training activities in such fields as storage, distribution and the proper use of drugs; and through identifying suitable training facilities for various categories and levels of staff and providing fellowships in both developed and developing countries for the preparation and implementation of national drug policies. In view of the lack of personnel experienced in management, training, quality assurance, procurement, storage and the logistics of supply in many national health administrations and in WHO, WHO will support training of personnel in these fields at the request of Member States, in collaboration with other organizations as appropriate. The training of personnel from developing countries will be arranged as far as possible in these countries, but also in developed countries;

(iii) facilitating intercountry cooperation in all areas mentioned above under that heading, and in particular TCDC for pool procurement by a group of countries.

32. Whenever WHO does not have the expertise within its ranks, it will seek it out wherever it is to be found on behalf of the requesting country. WHO’s technical cooperation role is not exclusive; the field is open to all interested parties to cooperate among themselves in fulfilment of the action programme. In all its technical cooperation activities WHO will use the objective information it has generated through its coordinating role. All other parties involved in the programme are also expected to use this kind of information.

Mobilization of resources

33. The action programme is a new endeavour for which the funds available, both to countries and to WHO, are inadequate. Most funds for the implementation of the programme
will be required by countries themselves. It is the responsibility of governments to allocate funds from national budgets and to request external funding as required from international sources. WHO's programme budget will be used to generate the information required by countries to develop their programmes as outlined above, to cooperate with them on request in applying this information in practice, and to help them mobilize the internal and external resources they require. Further details of the financial commitment of governments as well as WHO regional offices and headquarters are to be found in paragraphs 36(iii), 36(ix), 40, 40(x), 42(xiii), and 43.

34. As part of its coordinating role WHO, in cooperation with UNICEF, will seek the support of United Nations funds such as UNDP as well as bilateral and other multilateral agencies for essential drug programmes in developing countries. It will also facilitate negotiations between developing countries that so desire, the World Bank, regional banks, bilateral agencies and the pharmaceutical industry, with a view to obtaining credit, soft loans and loans under concessional terms for the development and implementation of essential drug programmes, as well as banking privileges for purchasing essential drugs in local currency from hard-currency countries.

V. ROLE OF GOVERNMENTS AND WHO AT COUNTRY, REGIONAL AND GLOBAL LEVELS

Country level

35. The action programme will encompass all countries that so desire. Participation may take the form of development and implementation of comprehensive national drug policies; contributions in cash, in kind, or in the form of credit, loans or currency convertibility privileges; or international collaborative efforts in research, training and manpower development. Governments desirous of implementing the action programme within their own country will be expected to accept certain criteria to make their efforts effective. WHO has a responsibility to try to influence countries to do so and to support the mobilization of international resources for those programmes that comply with the criteria. It also has a responsibility to cooperate with countries to identify needs for WHO support in the light of the criteria.

36. The following are the main criteria:

(i) commitment to the goal of health for all by the year 2000 through primary health care;

(ii) a national commitment to identify countrywide needs for drugs and to establish on this basis a national drug policy accordingly; and to plan and implement a permanent essential drugs programme and evaluate the results;

(iii) allocation of national financial resources and personnel to the programme on a long-term basis;

(iv) definition of managerial responsibility for the programme, preferably by the appointment of a national manager or coordinator who has the competence, experience and authority to develop and implement the programme;

(v) formulation of realistic plans to identify national therapeutic needs for primary health care, select essential drugs to meet those needs, quantify essential drug requirements, obtain selected drugs at lowest possible cost while assuring that drugs selected are of adequate quality, assure effective domestic distribution, use drugs properly, and enact and enforce necessary legislation (in conformity with the principle of social equity, particular attention must be paid to persons who are socially or economically disadvantaged);

(vi) formulation of realistic plans, including allocation of resources, to develop and strengthen necessary national infrastructures for efficient and effective drug procurement, distribution, storage, quality assurance and management, as an integral part of the general health system infrastructure based on primary health care, and involving the infrastructures of other sectors as necessary;
(vii) formulation of realistic plans, including allocation of resources, to supply technical and managerial manpower needed to operate effective drug supply, quality assurance, distribution and managerial systems through appropriate training and development programmes and provision of appropriate long-term career opportunities;

(viii) development and implementation of the simplest possible effective systems to monitor and evaluate progress, including the review of patterns of drug prescribing and use, the measurement of coverage and the assessment of operational efficiency;

(ix) review of financial needs and ways of financing and mobilizing national and external funds, as necessary, through presentation of national plans.

37. Wherever applicable the WHO programme coordinator in the country will act to ensure WHO's cooperation in any or all of the above at the request of the government. UNICEF representatives will be closely involved.

Regional level

38. Regional committees, supported by the regional offices, will consider ways that are most appropriate in the region concerned of actively promoting the development and implementation of the action programme in Member States and ensuring cooperation to meet the criteria outlined above. They will adopt flexible responses in ensuring such cooperation, recognizing that each country's needs and capacities to respond to them are specific.

39. Regional committees will again be asked to decide on the distribution of responsibilities among Member States with respect to quality control laboratories and regional or subregional storage facilities as part of intercountry distribution systems.

40. In each regional office an adequate group of staff with suitable budgetary provisions for programme activities will be made responsible for the action programme. Such staff should identify expertise in, or relating to, the region that could be brought to bear on the programme in the region, and will call on such expertise as necessary. Some regions may wish to set up formal technical advisory committees. Regional staff responsibilities will include the following - it being understood that activities in countries would be carried out at the request of Member States:

(i) to ensure technical cooperation with Member States for the preparation and implementation of national drug policies and programmes based on the concept of essential drugs, particularly primary health care, as outlined in paragraph 27 above;

(ii) to disseminate to countries, through national health authorities, information for drug prescribers and nonprofessional primary health care workers and assist them in adapting global information to national needs;

(iii) to ensure the availability of the expertise required by countries in such areas as the preparation of drug policies, the estimation of quantified needs, local formulation and production, and procurement;

(iv) to facilitate and support TCDC for pool procurement by groups of countries;

(v) to support the establishment as necessary of regional or subregional centres for quality control testing of drugs, and possibly centres for individual countries if required, making sure that the most suitable expertise is engaged in such efforts;

(vi) to support countries in identifying training needs and developing training programmes, and to organize intercountry training as required;

(vii) to identify priority research needs at the regional level;
(viii) to ensure close collaboration at country level, in the context of primary health care, between the action programme and other programmes, such as the Expanded Programme on Immunization, the Special Programme for Research and Training in Tropical Diseases, the diarrhoeal diseases control programme, the malaria action programme, and other disease control programmes;

(ix) to establish regional lists of experts in the diverse fields involved, to use them in technical cooperation with Member States, and to advise Member States wishing to engage them directly on the terms of their availability;

(x) to identify regional resource needs in support of countries' individual and group activities and to provide technical support concerning drugs to country health resource groups consisting of bilateral and multilateral partners together with the host country;

(xi) to evaluate the efficiency and effectiveness of the regional programme.

Global level

41. The World Health Assembly has a decisive role in developing further the worldwide policy basis for the action programme and in monitoring and controlling the implementation of that policy. The Executive Board has the responsibility of advising the Health Assembly on the above, giving effect to the Assembly's decisions, and monitoring and evaluating the programme on its behalf. To this end, it will prolong the mandate of its Ad Hoc Committee on Drug Policies. In view of the unusual scope and complexity of the programme, the Director-General will consider appropriate ways of ensuring sound technical advice to the Organization.

42. The major responsibility of the Secretariat at the global level will be to develop and coordinate, on behalf of the Board and Health Assembly, a programme containing country and regional programmes and interregional and global activities. This will include setting global objectives, targets, and priority global research needs. The responsibilities include the following:

(i) to support the Executive Board and the World Health Assembly in developing policy, preparing strategies and time-limited plans of action, and fostering their implementation;

(ii) to identify potential partners in the programme, including organizations in the United Nations system, bilateral and multilateral agencies, nongovernmental organizations and pharmaceutical firms, and to negotiate the nature and extent of their participation;

(iii) to provide guidelines for formulating and implementing all aspects of national drug policies for adaptation and use by regions and countries;

(iv) to ensure, on request, technical advice and support to regions, and in collaboration with them to countries, in all aspects of drug requirements, supply, distribution, storage, purchase, production and proper use;

(v) to provide, in cooperation with UNICEF, guiding principles for pool procurement of drugs, support regions in applying them, and facilitate negotiations on the terms of purchase between countries or groups of countries and drug companies;

(vi) to ensure training as required at the interregional level;

(vii) to ensure the availability of information on national drug legislation and provide examples of model legislation or regulations;

(viii) to promote research of global significance for the development and proper use of drugs, including investigations on methodology to assess quantities of essential drugs needed by countries;
(ix) to develop communications plans to ensure appropriate knowledge about the action programme on the part of the World Health Assembly and the Executive Board, other organizations of the United Nations system, nongovernmental organizations, and other potential partners;

(x) to develop and maintain the active collaboration of the international pharmaceutical industry with the programme;

(xi) to ensure close collaboration at global level, in the context of primary health care, between the action programme and other programmes such as the Expanded Programme on Immunization, the Special Programme for Research and Training in Tropical Diseases, the diarrhoeal diseases control programme, the malaria action programme, and other disease control programmes;

(xii) to identify technical and managerial expertise, whether in government, academic circles, industry, consulting firms, etc., to use this expertise as necessary, and to advise regions on the terms of its availability;

(xiii) to mobilize global resources in support of countries' individual and group activities, whether through the global Health Resources Group for Primary Health Care, through country health resource groups, or by facilitating negotiations with international banks and industry for credit, favourable loans and hard currency convertibility privileges;

(xiv) to evaluate the efficiency and effectiveness of the global programme.

43. The organizational structure of the programme at headquarters will conform to the normal pattern of programmes whose secretariat activities are funded mainly by WHO's regular budget. An adequate group of staff with suitable budgetary provisions will manage and coordinate the programme.

VI. PLAN OF ACTION FOR 1982-1983

44. The following activities will be given priority during 1982-1983. They will be carried out within existing regular budget provisions for that biennium and from available extrabudgetary resources:

DEVELOPMENT OF NATIONAL DRUG POLICIES

Action by countries

45. Interested countries will:

(i) initiate the development of a national drug policy by taking the necessary political, managerial and financial steps along the lines indicated in paragraph 36 above;

(ii) appoint a manager or coordinator for drug policy development and implementation;

(iii) start to prepare realistic plans along the lines indicated in paragraphs 27 and 36 above, beginning by identifying therapeutic needs, selecting essential drugs, and organizing the distribution and supply system;

(iv) if they have already started the process, continue to develop their national drug policies along the lines of paragraphs 27 and 36 above.

Action by regional level of WHO

46. On government request, this level will:

(i) ensure that the necessary expertise is made available to countries through either WHO staff or outside experts;
select a few countries initially, in consultation with UNICEF as appropriate, based on such criteria as the seriousness of the government's interest in and commitment to primary health care and a national drug policy as part of it, as well as the level of socioeconomic development. An additional criterion will be the potential for arriving at successful outcomes - for example where bilateral and multilateral agencies are working together with a host country and it can be expected that basic resource support will be made available. It is essential to have a few success stories as an example and encouragement to others;

collect information on national drug policies and programmes.

Action by global level of WHO

47. This level will:

(i) provide appropriate guidelines, whether these emanate from WHO or from other sources; for example, the second report of the WHO Expert Committee on the Selection of Essential Drugs (Technical Report Series, No. 641); Guiding Principles for the Managerial Process for National Health Development ("Health for All" Series, No. 5); and "Managing drug supply - the selection, procurement, distribution and use of pharmaceuticals in primary health care", prepared by Management Sciences for Health, Boston, Massachusetts, United States of America (supported by the United States Agency for International Development (USAID) and a technical services agreement with WHO);

(ii) specify further the various components of a national drug policy and provide this information to countries;

(iii) take measures to ensure the collection and dissemination of reports on successfully developed national drug policies, with the agreement of countries concerned;

(iv) disseminate objective information on the proper use of drugs for different levels of the health system and different categories of health workers;

(v) support regional offices on request;

(vi) encourage bilateral and multilateral agencies having the requisite technical expertise to cooperate with developing countries in this endeavour and to make use of the global guidelines, and coordinate their efforts;

(vii) identify appropriate expertise on the subject as a whole as well as on specific fields, and provide information to the regions on the terms of availability of the various experts.

PROCUREMENT

Action by countries

48. Interested countries will:

(i) quantify needs, in terms of total quantities, as well as location and frequency of replenishment required to ensure continuity of supply within the country;

(ii) set up mechanisms for pool procurement if appropriate;

(iii) decide whether to participate in group pool procurement through intercountry agreements.
Action by regional level of WHO

49. This level will, in cooperation with UNICEF as appropriate:
   (i) ensure technical cooperation at the request of governments;
   (ii) facilitate TCD for group pool procurement, taking into account intercountry political, legal, financial and operational arrangements;
   (iii) identify needs for quality assurance, depending on sources of drugs, and initiate any action required in this area, making sure that the most suitable expertise is involved.

Action by global level of WHO

50. In cooperation with UNICEF, this level will:
   (i) facilitate negotiations with the pharmaceutical industry on the terms and conditions of purchase by developing countries of essential drugs for their underserved populations;
   (ii) ensure the availability of expertise required by regional offices to facilitate TCD arrangements for group pool procurement;
   (iii) encourage additional Member States to accept the WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce.

MANPOWER DEVELOPMENT

Action by countries

51. Interested countries will:
   (i) prepare a manpower development plan to ensure drug policy development and implementation;
   (ii) provide training - on the spot, in other countries through intercountry arrangements, and in indigenous industry where this exists.

Action by regional level of WHO

52. This level will:
   (i) support national training activities on request;
   (ii) organize intercountry training courses as necessary;
   (iii) facilitate training through TCDC;
   (iv) ensure training in specific subjects through appropriate placement and fellowships, for example, in planning and management of distribution and supply systems.

Action by global level of WHO

53. This level will:
   (i) provide training material;
   (ii) support regions on request;
   (iii) encourage bilateral agencies and the pharmaceutical industry to provide training in their particular fields of competence.
MOBILIZING FINANCIAL RESOURCES

Action by countries

54. Interested countries will:

(i) rationalize the use of resources by focusing on selected lists of essential drugs and by ensuring that any additional funds for drugs are allocated to primary health care and its immediate referral level;

(ii) study innovative ways of making drugs available to individuals and communities;

(iii) study ways of ensuring the replenishment of drug supplies as necessary;

(iv) include as necessary requests for the essential drugs programme in requests for external resources to implement the national strategy for health for all.

Action by regional level of WHO

55. This level will, in cooperation with UNICEF as appropriate:

(i) facilitate arrangements with regional banks for credit, soft loans, hard-currency privileges and other possible arrangements for procurement of drugs by developing countries for their underserved populations, based on best estimates of the sums involved;

(ii) promote the study, by groups of bilateral and multilateral agencies together with the host countries, of the best ways of ensuring financial resources for the implementation of well-defined national drug policies.

Action by global level of WHO

56. In cooperation with UNICEF, this level will:

(i) hold discussions with representatives of the pharmaceutical industry with a view to obtaining the most favourable terms and conditions for the procurement of essential drugs by developing countries for their underserved populations;

(ii) encourage bilateral and multilateral agencies to provide financial support to drug programmes of developing countries and apprise the global Health Resources Group for Primary Health Care of the financial needs of developing countries for drugs as part of their strategies for health for all, with a view to obtaining grants or soft loans;

(iii) facilitate negotiations to obtain for developing countries credit, soft loans and hard-currency privileges from the World Bank and other international banks based on best estimates of the sums involved;

(iv) inform the Executive Board and the World Health Assembly of extrabudgetary requirements to carry out WHO's activities.

LEGISLATION

Action by countries

57. In some countries it will be necessary to introduce appropriate legislation immediately. These countries should identify their needs along the lines outlined in paragraph 27(xi), which deals with legislation, and should legislate as necessary to satisfy these needs.
Action by regional level of WHO

58. This level will provide technical support on legislation, at the request of governments, and ensure the availability of outside expertise as necessary.

Action by global level of WHO

59. This level will:

(i) ensure the availability to countries of information on drug legislation throughout the world;

(ii) provide guidelines and models for preparing relevant legislation that can be adapted by countries to their specific needs.

MONITORING AND EVALUATION

60. A detailed work plan for 1982-1983 will be prepared. In addition to facilitating implementation, this will permit the monitoring of progress and evaluation of the effectiveness of the programme. The work plan will be reviewed by the Executive Board's Ad Hoc Committee on Drug Policy immediately after the Thirty-fifth World Health Assembly, and the first monitoring of progress will be carried out by the Executive Board at its seventy-first session in January 1983.

Appendix

ACTIVITIES UNDERTAKEN IN THE WHO REGIONS AND AT THE GLOBAL LEVEL

African Region

1. In the African Region studies on drug policies and management have been carried out in more than 12 countries, with the participation of national experts, Regional Office and headquarters staff. The main objective was to develop national drug policies and technical cooperation in the field of pharmaceuticals.

2. Short reports on country visits as a part of these studies appear below.

(i) Burundi

From 1979, following a request from the Ministry of Health, the country drug supply situation has been analysed. WHO staff have worked in collaboration with the pharmaceutical industry, experts being contributed by Ciba-Geigy, Hoffman-La Roche, Sandoz, and Smith, Kline & French. The study has focused on:

(a) national drug policy, including the selection and quantification of essential drugs;

(b) development of infrastructure for drug supply;

(c) strategy for improvement of the present situation, including local formulation of selected essential drugs and development of managerial expertise;

(d) development of short- and medium-term plans of activities for the implementation of the above.

A progress report on the Burundi project is being prepared.

(ii) Botswana

In collaboration with the Ministry of Health, WHO has helped in the development of national drug policies and provided experts on drug legislation and local formulation. Additional inputs - for example, work on the establishment of a list of essential drugs, drug supply and distribution, and quality assurance towards the establishment of a national drug policy - have been undertaken with the collaboration of the Government of Norway. As a consequence, two Norwegian pharmacists will work in Botswana for one year, one in the Central Medical Stores, and the other to assist in the establishment of a quality assurance system.
(iii) Gabon

WHO staff visited Gabon in 1981, primarily to collaborate in the formulation of a national drug policy. Several recommendations were made to the Government. These include revision of the national formulary and improvement of quality assurance, drug legislation, and the distribution and procurement systems.

(iv) Gambia

The Government has been assisted by a number of United States pharmaceutical companies in the identification of essential drugs, introduction of a supply system, training for quality assurance, and the provision of adequate storage facilities. In addition, at the request of the Ministry of Health, WHO has recently reviewed the existing drug laws in Gambia and submitted proposals for new draft legislation on pharmaceuticals, primarily to serve as the basis for a national drug policy.

(v) Ghana

At the request of the Ministry of Health, WHO has collaborated in the improvement of local formulation of essential drugs. Recently interest has also been evinced in cooperation in the formulation of national drug policies.

(vi) Kenya

In 1979, the Ministry of Health launched a programme to improve the level of health care for the rural population of Kenya. At the initial stage, WHO provided experts to assist the essential drugs programme drawn up by a national task force. This included a situation analysis and the setting up of an appropriate drug management and supply unit. The objectives of this unit are to increase the availability of a limited range of essential drugs, suitably packed in appropriate quantities, to the rural health facilities; to improve the usage of drugs; and to prevent wastage by better management and training of health workers. A standard list of essential drugs, manuals for clinical diagnosis and management of patients, including standard treatment schedules, drug rations/ration kits, public information on drugs, etc. have been developed. Most of this work was done by the Ministry of Health in collaboration with Danish International Development Agency (DANIDA) experts. Pilot programmes in two districts have been tested with great success. This can be deduced from the overall reaction and enthusiasm of health workers at all levels, and the significant decrease in the number of patients coming from the rural areas to the district hospitals since the introduction of the programme. The programme is now being expanded to other districts. DANIDA has provided Kenya with experts for the implementation of this programme. The Swedish International Development Agency (SIDA) is considering supporting Kenya in a programme on essential drugs. UNICEF has provided expertise for international procurement as well as aid for the cost of quality control analysis. Collaboration is anticipated in implementation of a rural health programme by providing an adequate infrastructure development for the supply of essential drugs.

(vii) Lesotho

The Government of Lesotho, aided by the Government of the Netherlands, the Dutch Development Bank and other donors, and with the technical support of the International Dispensary Association (a non-profit pharmaceutical service organization), established the Lesotho Dispensary Association (LDA) in 1977. LDA manufactures and distributes drugs to several medical institutions in Lesotho. Further enlargement of its facilities is being undertaken so as to satisfy to its best capacity subregional and regional requirements.
(viii) **Mauritius**

A WHO consultant visited Mauritius in 1980 to analyse the drug supply situation and identify problems. Several alternative approaches were recommended to the Government for improvement of the present situation.

(ix) **Rwanda**

Following discussions with the Government, a fact-finding mission was undertaken in 1980. This mission included Danish experts in collaboration with experts from the Danish pharmaceutical industry and WHO staff. The drug supply situation was studied and the constraints identified. A set of recommendations was proposed to the Government, including the holding of a national workshop, mainly with the purpose of formulating a national drug policy. Proposals for the funding of this workshop were made to DANIDA, and these have been accepted in principle. A pilot project in Butare for local formulation facilities is being supported by the Belgian Government.

(x) **Senegal**

WHO, in collaboration with national experts, has studied the drug supply situation in Senegal. The French Government and a French group of industries (SNIP) have shown interest in collaborating, particularly in the areas of quality control, distribution, and manpower development. The **World Bank** will provide a loan for the development of distribution facilities in the rural areas, the purchase of some equipment for local formulation facilities, and the import of raw materials for essential drugs.

(xi) **Swaziland**

Following a request from the Ministry of Health, WHO staff studied the country drug supply situation in 1981, proposed the revision of drug legislation, and made other recommendations for improvements.

(xii) **Mozambique**

In 1977, Mozambique developed a national pharmaceutical policy in keeping with the objective of expanding health services. Under this policy essential drugs are provided free of charge. A national drug formulary was published in 1977 and revised for the first time in 1980. After the formulary, a national therapeutic guide was developed and distributed. The above activities have been implemented entirely by the Ministry of Health, WHO collaborating in the field of drug distribution and quality control.

3. According to the information received at WHO, the following countries have established, or are in the process of establishing, collaboration with bilateral agencies in the field of pharmaceuticals in the African Region:

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<tr>
<th>Countries in Region</th>
<th>Cooperating countries</th>
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<td>Botswana</td>
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<td>Ghana</td>
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<td>Belgium, Denmark</td>
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<td>United Republic of Tanzania</td>
<td>Denmark, Finland, Netherlands, Sweden</td>
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4. During 1980 and 1981, drug policies and management and TCDC in the field of pharmaceuticals were discussed at several meetings in the African Region, with the aim of promoting the establishment of national drug policies in accordance with the primary health care approach. These meetings included the Regional Committee itself as well as meetings of experts at the regional level.

5. A list of essential drugs, vaccines and sera has been agreed upon by 33 Member States of the Region and is intended to form a basis on which these countries can pool procurement facilities. It is anticipated that WHO and UNICEF will collaborate on administrative, technical and financial mechanisms.

Region of the Americas

6. In the Region of the Americas, resolution XXIII of the thirty-second session of the Regional Committee (1980) requires study of mechanisms for collective purchase of large quantities of selected health inputs, including drugs. The use of revolving funds and other mechanisms for drug procurement is being developed.

7. The Organization has collaborated with governments of the Region in the development of national drug formularies, which are being increasingly recognized by health authorities as important tools to rationalize drug procurement in the public sector. The subsequent step is the establishment of subregional formularies to serve as the basis for planning subregional production and bulk purchases, as in the Andean Pact countries.

8. Several national, subregional and regional meetings have been organized to promote WHO’s policies on quality control and good manufacturing practices, and to discuss the use of generic names (INN) and the need to coordinate drug regulatory activities. A meeting to promote the formulation of national drug policies in the Region was convened in October 1981 with the participation of 12 countries.

9. In the English-speaking Caribbean, the Organization has supported the establishment of a Caribbean drug testing laboratory to serve the area in specialized pharmaceutical assays (toxicological and microbiological). One professional staff member has been recruited by the Organization to assist in this control laboratory.

10. In Brazil, collaboration continued in the development of an integrated national drug control system, with financial support from UNDP.

11. The Organization has received active collaboration from industry in the Region. National and subregional short-term courses on good manufacturing practices and plant inspection were organized by the Organization’s regional drugs control programme.

12. Regular information in Spanish on the safety and efficacy of drugs has been provided in a special quarterly section of the Boletín de la Oficina Sanitaria Panamericana.

13. An interdisciplinary operational research project has been undertaken to assess the management and use of drugs in selected health centres, hospitals and health posts. In five countries, deficiencies were apparent at various levels of the pharmaceutical supply systems, from selection and procurement to distribution and use. The problems will be analysed and approaches will be developed for their solution. The need to strengthen health infrastructures to deliver drugs to patients at the primary health care level will also be studied.

14. A number of other country and intercountry activities are in progress in the Region of the Americas, with or without the Organization’s direct involvement, for example:

(i) The development of subregional drug policies among the Caribbean Community and Andean Pact countries.

(ii) Barbados - a drugs service for the public sector which provides centralized procurement, coordinates distribution, and monitors use.
(iii) Cuba, Guyana, and to a degree Mexico have a comprehensive national intersectoral drug policy and are now in the stage of implementation.

(iv) Ecuador - the Ministry of Health is collaborating with PAHO/WHO in the formulation of national drug policies.

(v) Guatemala has initiated government quality control activities. A project proposal for the development of a national quality control programme is under consideration by UNDP.

(vi) Haiti has started collaboration with USAID in the supply of essential drugs.

(vii) Panama is working to strengthen its drug supply management.

(viii) Peru is undertaking an essential medicines programme with industry's collaboration to supplement the established basic drug programme.

South-East Asia Region

15. In the South-East Asia Region various activities have been undertaken with regard to the action programme. As early as 1977 country visits were made by Regional Office staff in collaboration with headquarters. In consequence a regional seminar was held in Colombo in 1978 and technical discussions on drug policies and management were held during the Regional Committee's session in November 1979. Comprehensive information is now available on the pharmaceutical supply situation in each country of the Region. Critical areas of the drug supply situation at country and regional levels have been identified and recommendations for improvement have been discussed. A meeting on TCDC among the Member States of the Region took place in 1980 and areas of possible cooperation were identified. Funding for this activity is under consideration by UNDP.

16. Bangladesh. In 1977 WHO staff, in collaboration with national experts, analysed the drug supply situation and identified deficiencies. A short list of 31 essential drugs for primary health care was drawn up. Various activities have been carried out since then, among others secondment of a WHO expert to collaborate in the construction and running of the new Government Pharmaceutical Production Unit (GPPU), supported partially by UNICEF in the form of production machinery. In the field of local formulation the Government of the Netherlands has also provided financial support to Bangladesh. A loan for the purchasing of raw materials needed for the local formulation of essential drugs has been worked out by the Asian Development Bank (ADB) and proposed to the Government of Bangladesh.

17. Burma. After studying and analysing the drug supply situation in Burma, the Ministry of Health has undertaken several activities in collaboration with WHO, such as the establishment of lists of essential drugs for the different levels of health care, improvement of the formulation capabilities of the Burma Pharmaceutical Industry (BPI), with the financial assistance of UNICEF, and the establishment of a national quality control laboratory with the financial assistance of UNDP. Contact has been established with potential donors and financial institutions to mobilize funds needed for the extension of BPI. The Government has received a loan from the Asian Development Bank for its essential drugs programme.

18. Indonesia. A comprehensive national drug policy was formulated by the Government in collaboration with WHO and with financial support from UNDP. It includes the establishment of lists of essential drugs for the different levels of health care, new registration procedures, drug monitoring systems, the review of drug legislation, manpower training, etc. The Asian Development Bank, in collaboration with WHO, has undertaken the required feasibility studies in the field of local formulation of some essential drugs for primary health care. The Japanese Government has shown interest and has, in principle, agreed to assist with the establishment of a national quality control laboratory. Experts in drug and food control have been seconded by the Federal Republic of Germany. The expansion of vaccine and sera production has been partially financed by USAID.
19. Mongolia. The drug supply situation in Mongolia was studied by WHO staff in 1981. WHO's collaboration has been requested for the strengthening of production of intravenous fluid in plastic containers.

20. Nepal. The country drug supply situation was analysed in 1977 and recommendations for improvement have been discussed. For the strengthening of local formulation capabilities, Nepal's Royal Drugs Ltd has received technical and financial support from the Government of the Netherlands, UNDP, UNICEF, WHO and UNIDO. Drug utilization studies were initiated in 1982 with WHO staff support. A programme for drug delivery to the three mountainous districts is being finalized.

21. Sri Lanka. A feasibility study for the establishment of government local formulation plant was undertaken together with experts from the State Pharmaceutical Cooperative (SPC). Funding agencies have been approached for the financing of this project. The Asian Development Bank sent a mission to carry out feasibility studies on local formulation and drug distribution. The Swiss Government has collaborated with UNIDO in the financial support of the essential drugs programme.

22. Thailand. The country drug supply situation was analysed in 1977. A national drug policy has recently been formulated by the Government and a national list of essential drugs has been drawn up. Collaboration in the preparation of a plan of action for the implementation of the newly formulated national drug policy and for drug utilization studies and manpower training is anticipated.

European Region

23. The main areas of interest in the European Region are clinical pharmacology, drug evaluation, and drug utilization. The European Regional Office has helped in the establishment of bilateral agreements between developed and developing countries.

24. Countries in the European Region have shown keen interest in the action programme, and have extended their support, particularly to the governments of developing countries in the form of training of manpower and direct financial and technical support on a bilateral basis.

25. A survey of the pharmaceutical supply system has been carried out in Morocco. WHO has started collaboration in reviewing the national lists of essential drugs for the public sector and, jointly with UNICEF, in studying the feasibility of setting up a new government formulation plant for some primary health care drugs.

Eastern Mediterranean Region

26. In the Eastern Mediterranean Region, simplified utilization studies to collect data on drug requirements and cost per capita per year have been carried out in Djibouti, Somalia, and Sudan.

27. WHO and UNICEF sent a joint mission to Sudan in 1981 at the request of the Ministry of Health to assist in formulating an appropriate national policy based on primary health care and the essential drugs concept. A plan of action has been drawn up and WHO has assisted the Government in the selection and quantification of essential drugs for the different levels of health care, drug distribution, management of the central medical store and quality control aspects. UNICEF is supplying Sudan with some essential drugs for primary health care. According to information received by WHO, the Federal Republic of Germany is interested in supporting the development of a drug distribution infrastructure in southern Sudan.

28. WHO staff, with the participation of experts from the pharmaceutical industry, analysed the drug supply situation in Somalia and Yemen. Somalia has signed an agreement with an Italian pharmaceutical group (Pharmex) for the supply of some essential drugs for the primary health care programme. This agreement includes training for Somali nationals in drug distribution, quality control, and drug management, as well as the provision of experts from Italy. Substantial progress is reported to have been made.
29. Technical and financial support was provided for the establishment of a standard reference laboratory in Egypt.


Western Pacific Region

31. In the Western Pacific Region, emphasis has been placed on the development of a joint purchasing system for the South Pacific countries. A common list of essential drugs has been established for these countries. Several consultants have been provided by WHO to work out the technical, financial, administrative and legal aspects of this programme, which includes bulk purchasing, quality control and storage facilities, and distribution mechanisms. There are several constraints and progress has therefore been slow.

32. Collaboration has been initiated with China in the fields of medicinal plants and biologicals. China has expressed its willingness to collaborate with the action programme for the supply of certain essential drugs at very favourable prices. An interregional meeting on the standardization and use of medicinal plants was held in China in November 1980.

33. The Regional Office has collaborated in the programmes of essential drugs in the Lao People's Democratic Republic and Viet Nam.

Lessons from the country studies

34. More than 40 country studies have been undertaken at the request of Member States in all the regions. These studies were aimed at analysing the pharmaceutical supply situation and assessing the extent of the application of national drug policies and management systems. The studies were carried out by national experts and WHO staff with, in some cases, the collaboration of experts from the pharmaceutical industry. The experience gained from the various missions undertaken shows also the extent of interregional activities.

35. The following lessons have been learned from the studies:

(i) Problem analysis in situ is important to support Member States in developing practical measures for improving their pharmaceutical supply situation.

(ii) Pharmaceuticals are an important component of national health delivery systems. The scarcity of financial and manpower resources makes the supply of pharmaceuticals difficult in most developing countries, particularly at the periphery. To ensure that pharmaceuticals are available to all who need them, a combination is required of some or all of the following elements of a comprehensive drug supply system: selection, procurement, distribution, logistics of supply, quality assurance, essential information for proper usage, simple formulations, packaging and labelling, local production wherever feasible, and monitoring of adverse reactions.

(iii) To ensure the right combination, national drug policies and adequate strategies for implementing them are essential. A multisectoral approach is required, with the activities both inside and outside the country covering all sectors involved: health, education, planning, finance, industry, trade, etc. Such policies are particularly important if drugs are to play a major role in health delivery systems, especially through primary health care, at costs countries can afford; the acceptance of the principle of essential drugs is of paramount importance. In applying these policies, cost-benefit analysis, the possible advantages of bulk purchasing, and various options for supply systems also have to be taken into account.

(iv) National commitment - in economic, political and administrative terms - is essential for the formulation and implementation of effective drug policies. This should reflect the economic capacity of the country. It is a continuing process of gradual and realistic improvement.
(v) To plan and implement a national drug policy, a national focal point has to be established.

(vi) There is a need for coordination of action:

(a) within the health sector, at the different operational and policy levels;

(b) among the health sector and other sectors involved, as well as nongovernmental organizations at country level;

(c) between the country concerned and external parties involved;

(d) among external parties concerned, at the international level.

Several organizations are providing inputs for drug supply to developing countries. Certain positive responses have been obtained from multilateral and bilateral agencies, nongovernmental organizations and philanthropic bodies for the supply of essential drugs. The coordination of these efforts and, especially, of within-country supply systems, both of the government and of non-profit-making organizations, is an important component of the strategy; however, any action in this respect is a matter for national decision. WHO can play an effective coordinating role to facilitate relationships between the various parties.

(vii) There is a need for technical cooperation between developed and developing countries, especially to enable the transfer of know-how and technology. For the implementation of the components of a national drug supply system that are temporarily beyond a country's capabilities, the TCDC approach would be the best solution.

36. The following is a summary of the TCDC activities noted during the country studies.

(i) In the African Region several regional and subregional meetings have been held to develop concrete plans for group bulk purchase, quality control, and training of manpower.

(ii) In the Region of the Americas there has been cooperation among various Member States and subregional groups (such as the Andean Pact countries and the Caribbean Community) since as early as 1973. This activity mainly focuses on uniform legislation in the health field, including pharmaceuticals and quality assurance.

(iii) In the South-East Asia Region plans have been initiated for TCDC among Member States, and two meetings have been organized to discuss areas for TCDC among countries of the Region.

(iv) As an example of interregional cooperation between the South-East Asia and Western Pacific Regions, the ASEAN countries have developed programmes and received financial support from UNDP for technical cooperation in the following areas: exchange of information, manpower development, good manufacturing practices, development of reference substances, quality control, and drug evaluation.

(v) In the European Region, where nearly all Member States are industrialized, there has been intercountry collaboration in the field of drug utilization and exchange of information, and Member States have also shown interest in collaborating with developing countries in other regions in both the public and private sectors.

(vi) In the Eastern Mediterranean Region the Islamic Development Bank and the League of Arab States have taken preliminary steps regarding the supply and quality control of pharmaceuticals.

(vii) In the Western Pacific Region the South Pacific Bureau for Economic Cooperation has initiated the establishment of a South Pacific joint pharmaceutical service which includes: bulk procurement, quality control, storage and repackaging facilities, and manpower
Global level

37. At the global level the action programme on essential drugs has developed:

(i) a model list of essential drugs;¹

(ii) guidelines for the establishment of a low-cost formulation plant in developing countries;

(iii) basic elements of drug legislation and regulatory control for developing countries.

Information sheets on essential drugs for the different levels of health care worker are in the final stages of preparation and field testing.

38. Other work in preparation includes: guidelines on the formulation of national drug policies; guidelines on drug distribution and management; manuals for the training of primary health care workers in the proper handling of a limited number of essential drugs; and a manual on the use of the most widely employed medicinal plants.

39. At the request of the regional offices, technical support has been provided for the development of programmes on essential drugs at country and regional levels. This support includes:

(i) preparation of technical documents for regional/subregional meetings on the various components of drug policies and management;

(ii) evaluation of country needs for essential drugs;

(iii) provision of expertise in analysing specific aspects of drug policies and management, e.g., the selection of essential drugs;

(iv) assistance in the preparation of project documents for submission to donors, to support the implementation of country and regional programmes;

(v) identification of training places and organization of training programmes.

40. Dialogue with the pharmaceutical industries has continued and several informal meetings have been held, both individually and collectively. The International Federation of Pharmaceutical Manufacturers Associations (IFPMA) and the World Federation of Proprietary Medicine Manufacturers (WFPMM) made a specific offer of collaboration with the action programme on training in quality control and good manufacturing practices. IFPMA offered, on behalf of member companies, to provide training in industrial laboratories for government technicians in the field of quality control, and WFPMM to provide training in good manufacturing practices. In the case of IFPMA's offer, transportation costs from the country to the training establishment are the responsibility of the government concerned. WFPMM's offer also includes transportation costs and some living allowance. To date six candidates have undertaken IFPMA's training programme and eight more candidates will follow. Two candidates for the three places offered by WFPMM are undergoing training.

41. Collaboration with other organizations in the United Nations system, such as UNICEF, UNDP, UNIDO and UNCTAD, has been developed in order to ensure their participation and support.

(i) With UNICEF, collaboration has been initiated in two major areas:

(a) The provision of some essential drugs to support the implementation of primary health care programmes in the least developed countries (LDCs).

(b) Pool procurement schemes for essential drugs for African countries. Joint visits by WHO and UNICEF staff were undertaken in Morocco and Sudan, and several joint meetings were convened to discuss the setting up of an appropriate procurement scheme.

(ii) UNDP financial support is required at all levels for the programme. To date, financial support has been provided for some country and regional programmes, and for the ASEAN TCDC programme in pharmaceuticals.

(iii) Collaboration with UNIDO has related to: (a) the exchange of information on the production aspect of raw materials for essential drugs; (b) prices and sources of supply. WHO also participated in the preparation of background documentation for the UNIDO International Conference on Pharmaceuticals held in Cancun, Mexico, in 1980, and in Lisbon in 1981. A recent interagency meeting with UNIDO identified broad areas of mutual collaboration and utilization of expertise (especially at country level) in the field of pharmaceuticals.

(iv) Collaboration with UNCTAD is primarily on the exchange of information with regard to the transfer of technology and the international pharmaceutical trade, based on country surveys carried out by UNCTAD.

(v) Collaboration with the United Nations Centre on Transnational Corporations has also commenced.

42. While some countries have formulated comprehensive national drug policies based on primary health care and the essential drugs concept - for example, Afghanistan, Cuba, Democratic Yemen, Guyana, Malaysia, Mexico, Mozambique, Singapore, Somalia, Sudan and Thailand - others are in the process of formulating or revising the existing drug policies; these include Benin, Botswana, Brazil, Burundi, China, Congo, Ecuador, Ethiopia, Fiji, Gabon, Ghana, India, Indonesia, Kenya, Madagascar, Nigeria, Peru, Philippines, Rwanda, Senegal, Togo, Zaire, and Zambia.

43. In addition to what has been done in this field by the developed countries, some 70 developing countries have established lists of essential drugs for the public sector or national formularies. These are listed below, according to information available in WHO:

African Region
Angola, Botswana, Burundi, Cape Verde, Comoros, Congo, Ethiopia, Gambia, Ghana, Guinea-Bissau, Kenya, Lesotho, Malawi, Mauritania, Mauritius, Mozambique, Rwanda, Seychelles, Togo, United Republic of Tanzania, Zaire, Zambia, Zimbabwe;

Region of the Americas
Argentina, Bahamas, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Peru, St Lucia, Suriname, Trinidad and Tobago, Uruguay, Venezuela;

South-East Asia Region
Bangladesh, Burma, India, Indonesia, Nepal, Sri Lanka, Thailand;
European Region
Algeria, Morocco;

Eastern Mediterranean Region
Afghanistan, Democratic Yemen, Somalia, Sudan;

Western Pacific Region
China, Malaysia, Samoa, Singapore, Solomon Islands, Vanuatu, Viet Nam.

44. It can be seen from the above that the action programme on essential drugs, in spite of limited funds, has made significant progress. Efforts have been concentrated so far on supporting countries in identifying their problems and needs, in laying the ground for improving their drug supply systems, and in formulating national drug policies based on primary health care. The climate that has been created and the response from Member States augur well for the future.
ANNEX 7
EXPANDED PROGRAMME ON IMMUNIZATION

For the information of the Executive Board, the Director-General prepared a progress and evaluation report on the Expanded Programme on Immunization which he submitted to the Board's sixty-ninth session, in January 1982 (document EB69/25). That report summarized the progress since the report to the Thirty-first World Health Assembly (May 1978) and proposed a five-point action programme as a guide towards the achievement of the EPI goal of providing immunizations for all children of the world by 1990. With some corrections and updating, it is submitted herewith for the Health Assembly's information (see Appendix).

Attention is drawn to resolution EB69/R8, in which the Executive Board recommends the adoption by the Thirty-fifth World Health Assembly of a resolution recognizing that the EPI goal is an essential element of WHO's strategy to attain health for all and warning that progress will have to be accelerated if this goal is to be met.

Appendix

PROGRESS AND EVALUATION REPORT BY THE DIRECTOR-GENERAL

1. BACKGROUND

1.1 The Expanded Programme on Immunization (EPI) has its basis in resolution WHA27.57, adopted by the World Health Assembly in May 1974. General programme policies, including the EPI goal of providing immunizations for all children of the world by 1990, were approved in resolution WHA30.53, adopted in May 1977. The importance of EPI as an essential component of maternal and child health and primary health care was emphasized in resolution WHA31.53, adopted in May 1978, and in the Declaration of Alma-Ata in September 1978. EPI is an essential element within WHO's strategy to achieve health for all by the year 2000, and immunization coverage of children has been included among the indicators which WHO proposes to use to monitor the success of that strategy at global level.

2. SUMMARY OF EPI PROGRESS

2.1 EPI accomplishments are summarized below in terms of three indices: the proportion of children immunized (Table 1), the reported incidence of EPI target diseases (Fig. 1) and the quality of vaccines employed (Fig. 2). In addition, information concerning the number of

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1 See resolution WHA35.31.
2 The Board's comments on the report are reflected in the summary records of its session; see document EB69/1982/REC/2, pp. 196-209.
3 Document A31/21.
countries participating in various programme activities is presented in Table 2. These data remain incomplete, in part because the WHO regional information systems to obtain them from national level are themselves still being developed, and in part because they are not yet available at national level.

### Table 1. Estimated Percentage of Children Immunized in the First Year of Life and Percentage of Pregnant Women Immunized Against Tetanus, By WHO Region, During the Latest Period of 12 Months For Which Information Is Available (1978-1980)

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage of population covered by reports*</th>
<th>Percentage of children immunized by 12 months of age</th>
<th>Percentage of pregnant women immunized</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>BCG</td>
<td>Third dose</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DPT</td>
</tr>
<tr>
<td>Africa</td>
<td>**</td>
<td>54%</td>
<td>37%</td>
</tr>
<tr>
<td>Americas</td>
<td>60%</td>
<td>54%</td>
<td>37%</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>98%</td>
<td>27%</td>
<td>18%</td>
</tr>
<tr>
<td>Europe</td>
<td>26%</td>
<td>64%</td>
<td>70%</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>99%</td>
<td>25%</td>
<td>22%</td>
</tr>
<tr>
<td>Mediterranean</td>
<td>5%</td>
<td>74%</td>
<td>61%</td>
</tr>
</tbody>
</table>

* Where percentage differs for different vaccines, the highest percentage is shown.
** The information system to document these data is still under development.

2.2 Much has happened since 1977 when EPI's policies were endorsed by the Health Assembly. At that time, WHO was working with only a handful of countries to demonstrate the feasibility of multiple-antigen immunization programmes in the developing world. No EPI management training programmes had yet been developed. No agreement existed concerning the type of information needed at national, regional and global levels to monitor programme progress, and there was no routine reporting of immunization coverage or vaccine quality, at least in developing countries. Routine national reports on the incidence of EPI target diseases were received by most regions, although they were frequently late and often gave an unrealistic picture of the true incidence of the disease in question.

2.3 Between 1977 and 1982, EPI has progressed from being a WHO-sponsored initiative to being an operational programme of Member States. By the end of 1981, most of the countries of the world had become active in EPI, and over 4500 national and international staff had participated in intensive two-week EPI management training courses. Methods for performing surveys to estimate immunization coverage and the incidence of poliomyelitis, measles and neonatal tetanus had been perfected and had come into widespread use. In 1981, development of regional EPI information systems permitted the first estimates to be made of immunization coverage by region (Table 1) and data to be provided on the quality of the vaccines in use (Fig. 2). Research and development concerning the technology of storing and transporting vaccines has led to a marked improvement in national cold-chain equipment and methods.

2.4 But such progress is not enough; without major acceleration, EPI risks failure in reaching all children of the world by 1990. The consequences of such failure would be tragic: surveys promoted by EPI in the developing world have confirmed the previous estimates of the toll being taken by diseases such as measles, poliomyelitis and neonatal tetanus.
2.5 In the absence of immunization programmes, some four out of every 1000 school-age children will be disabled by poliomyelitis. This figure does not take into account those who have been afflicted by the disease and have subsequently died, or those who have recovered. Measles, which kills about two per 10,000 cases in the United States of America, kills two per 100 cases in the developing world, the figure rising to 10 or more per 100 cases in malnourished populations. Without immunization, almost all children will contract this disease. Neonatal tetanus accounts in many areas for 20-50% of the total infant mortality. Taken together, the six EPI diseases kill some five million children each year, and cripple, blind, or cause mental damage to five million more.

2.6 Programme success will require that a number of challenges are met in the immediate future. They can be described under five headings: the primary health care approach, human resources and training, financial resources, programme evaluation and adaptation, and research and development.

FIG. 1

WORLD: REPORTED INCIDENCE RATES PER 100,000 POPULATION FOR MEASLES, TETANUS AND POLIOMYELITIS, 1974-1980

These are the diseases which are expected to be among the most accurately diagnosed and reported, and the most influenced in the short term by immunization programmes. Yet their diagnosis and reporting remain major problems in many countries, and it is premature to conclude that any decline such as that reported during 1979 and 1980 for measles is real or that it reflects the start of a long-term trend.
### TABLE 2. NUMBERS OF COUNTRIES OR AREAS KNOWN TO BE INVOLVED IN SELECTED IMMUNIZATION ACTIVITIES, BY WHO REGION, AS OF 31 DECEMBER 1981

<table>
<thead>
<tr>
<th>Number of countries or areas in the region</th>
<th>Africa</th>
<th>Americas</th>
<th>South-East Asia</th>
<th>Europe 1</th>
<th>Eastern Mediterranean</th>
<th>Western Pacific</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Vaccines utilized:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- BCG</td>
<td>46 (100%)</td>
<td>43 (92%)</td>
<td>11 (100%)</td>
<td>26 (70%)</td>
<td>24 (100%)</td>
<td>29 (91%)</td>
</tr>
<tr>
<td>- DPT</td>
<td>46 (100%)</td>
<td>47 (100%)</td>
<td>11 (100%)</td>
<td>24 (65%)</td>
<td>24 (100%)</td>
<td>32 (100%)</td>
</tr>
<tr>
<td>- Measles</td>
<td>43 (94%)</td>
<td>44 (94%)</td>
<td>7 (64%)</td>
<td>22 (60%)</td>
<td>24 (100%)</td>
<td>18 (56%)</td>
</tr>
<tr>
<td>- Poliomyelitis</td>
<td>41 (89%)</td>
<td>47 (100%)</td>
<td>10 (91%)</td>
<td>25 (68%)</td>
<td>24 (100%)</td>
<td>31 (97%)</td>
</tr>
<tr>
<td>- Tetanus for women of childbearing age</td>
<td>31 (67%)</td>
<td>20 (43%)</td>
<td>9 (82%)</td>
<td>15 (62%)</td>
<td>15 (53%)</td>
<td></td>
</tr>
<tr>
<td>2. Reporting to WHO for 1980</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Total number of immunizations</td>
<td>21 (46%)</td>
<td>47 (100%)</td>
<td>10 (91%)</td>
<td>1 (3%)</td>
<td>22 (92%)</td>
<td>27 (84%)</td>
</tr>
<tr>
<td>- Immunization by age or dose</td>
<td>29 (62%)</td>
<td>10 (91%)</td>
<td>1 (3%)</td>
<td>22 (92%)</td>
<td>18 (56%)</td>
<td></td>
</tr>
<tr>
<td>3. Reporting to WHO the 1980 incidence of:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Diphtheria</td>
<td>25 (54%)</td>
<td>34 (72%)</td>
<td>9 (82%)</td>
<td>28 (77%)</td>
<td>19 (79%)</td>
<td>28 (88%)</td>
</tr>
<tr>
<td>- Measles</td>
<td>30 (65%)</td>
<td>44 (96%)</td>
<td>9 (82%)</td>
<td>25 (68%)</td>
<td>19 (79%)</td>
<td>29 (91%)</td>
</tr>
<tr>
<td>- Pertussis</td>
<td>28 (61%)</td>
<td>30 (64%)</td>
<td>9 (82%)</td>
<td>26 (70%)</td>
<td>18 (75%)</td>
<td>27 (83%)</td>
</tr>
<tr>
<td>- Poliomyelitis</td>
<td>33 (72%)</td>
<td>36 (77%)</td>
<td>9 (82%)</td>
<td>29 (78%)</td>
<td>21 (85%)</td>
<td>24 (75%)</td>
</tr>
<tr>
<td>- Tetanus</td>
<td>27 (59%)</td>
<td>43 (91%)</td>
<td>10 (91%)</td>
<td>26 (70%)</td>
<td>19 (79%)</td>
<td>26 (81%)</td>
</tr>
<tr>
<td>- Tuberculosis</td>
<td>28 (61%)</td>
<td>23 (49%)</td>
<td>10 (91%)</td>
<td>22 (60%)</td>
<td>18 (75%)</td>
<td>29 (91%)</td>
</tr>
<tr>
<td>- All of the above</td>
<td>19 (41%)</td>
<td>9 (19%)</td>
<td>8 (73%)</td>
<td>14 (38%)</td>
<td>16 (67%)</td>
<td>20 (63%)</td>
</tr>
<tr>
<td>4. Coverage evaluations, 1979-1981</td>
<td>21 (46%)</td>
<td>7 (15%)</td>
<td>7 (64%)</td>
<td>13 (35%)</td>
<td>12 (50%)</td>
<td>9 (28%)</td>
</tr>
<tr>
<td>5. Staff participating in:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- EPI planning and management course</td>
<td>41 (89%)</td>
<td>30 (64%)</td>
<td>9 (82%)</td>
<td>8 (22%)</td>
<td>17 (71%)</td>
<td>23 (72%)</td>
</tr>
<tr>
<td>- EPI mid-level management course</td>
<td>33 (72%)</td>
<td>30 (64%)</td>
<td>10 (91%)</td>
<td>2 (5%)</td>
<td>2 (8%)</td>
<td>9 (28%)</td>
</tr>
<tr>
<td>- EPI cold-chain course</td>
<td>7 (15%)</td>
<td>21 (45%)</td>
<td>10 (91%)</td>
<td>1 (3%)</td>
<td>8 (32%)</td>
<td>7 (22%)</td>
</tr>
<tr>
<td>6. Organization of EPI national mid-level management course</td>
<td>17 (37%)</td>
<td>39 (83%)</td>
<td>7 (64%)</td>
<td>2 (5%)</td>
<td>4 (17%)</td>
<td>8 (25%)</td>
</tr>
<tr>
<td>7. Incorporating EPI training materials in national training curricula</td>
<td>7 (15%)</td>
<td>7 (15%)</td>
<td>9 (82%)</td>
<td>1 (3%)</td>
<td>2 (8%)</td>
<td>8 (25%)</td>
</tr>
<tr>
<td>8. Programme reviews, 1979-1981</td>
<td>8 (17%)</td>
<td>5 (11%)</td>
<td>2 (18%)</td>
<td>1 (3%)</td>
<td>5 (20%)</td>
<td>2 (6%)</td>
</tr>
</tbody>
</table>

1. The information systems to document items 1-3 above are in the process of development. Few EPI activities (items 4-8 above) are shown in the European Region as most of the countries in the Region have well-developed immunization services and have not needed to initiate new activities as part of EPI.
2.7 Primary health care approach. Problems remain in promoting EPI using the approach of primary health care. One problem is to find more effective ways of involving the community as an active participant in the planning, implementation and evaluation of immunization programmes. A second problem is to provide immunization services together with other health services of relevance to pregnant women and young children, the groups of highest concern to EPI, and to ensure effective integration of their managerial support. Immunization coverage tends to be better when immunization is offered with these other services and, provided together, they reinforce each other to help break the vicious circle of malnutrition and infection which accounts for so much of the infant mortality in the developing world.

2.8 Human resources and training. Obtaining the investment of adequate human resources is the most difficult challenge faced by EPI. Current inadequacies are reflected in the frequent failures experienced in national cold-chain and logistics systems and in the low immunization coverage rates being achieved in many of the geographical areas which are at present included within national programmes. The low rates reflect the fact that appropriate numbers of staff have not been identified in many programmes, and that those who have been identified have often
not been given the responsibility or the authority to complete the tasks essential to the programme's success. Supervisory systems remain weak so that such staff are not held accountable for their performance. Although the training of 4500 senior staff is a start, few national programmes have yet developed strategies for teaching the basic EPI-related technical and supervisory skills to the hundreds of thousands of middle- and peripheral-level health workers who will carry out the bulk of the programme. Even fewer countries have developed means to encourage health workers to visit, train, motivate and monitor the performance of those for whom they are responsible. This is essential if the initial investments in training are not to be wasted.

2.9 Financial resources. It is estimated that in 1981 some US$ 72 million was invested in EPI in developing countries. This includes some US$ 12 million invested through multilateral agencies such as WHO, UNICEF and UNDP, and an equal amount invested by bilateral agencies. The remaining US$ 48 million came from within the national budgets of the developing countries themselves.

2.10 But EPI targets call for a doubling in the real value of these resources by 1983, and a further doubling by the end of the decade, when some US$ 300 million (at 1980 value) will be required annually. At least US$ 200 million will need to come from within the developing countries, the remaining amount from the international community. These targets will not be met without substantial acceleration in current investments. To ensure that enough vaccine is available to immunize by 1990 the 100 million children who will be born each year in the developing world, these investments must include support to increase vaccine production and quality control capacities.

2.11 Programme evaluation and adaptation. Most immunization programmes in the developing world, and some in the developed world, lack timely and reliable data concerning immunization activity and impact at national and local levels. Without data they cannot adapt their strategies for delivering services nor modify their training and supervisory practices to meet local needs, and they cannot improve with time. A combination of routine data collection and analysis and periodic comprehensive programme review is needed for all programmes. Routine data should include at least the elements of immunization coverage, disease incidence and information on whether the vaccines utilized meet WHO requirements. Comprehensive reviews can supplement the routine information and provide a mechanism for bringing programme needs to the attention of national decision-makers for remedial action. The impact of such reviews can be strengthened by having several professional disciplines represented, such as epidemiology, maternal and child health and economic and social sciences, by including users of services and by utilizing staff from outside the country as well as staff from within the country.

2.12 Research and development. The objectives of research and development within EPI are to improve the effectiveness of immunization services while reducing their costs and to ensure the adequate supply and quality of vaccines. Research and development activities, particularly those concerning practical aspects of the delivery of services, must be promoted as a part of national programme operations.

3. A FIVE-POINT ACTION PROGRAMME FOR THE 1980s

3.1 The EPI Global Advisory Group has met annually since 1978 to evaluate programme progress. During its most recent meeting, in October 1981, it reviewed a draft of this progress report.

3.2 The Global Advisory Group concluded that much progress had been achieved. But it also recalled that because immunization services in the developing world are still not generally available, 10 children die and another 10 children become disabled with each passing minute. It warned that the current rate of programme progress was not sufficient to achieve the EPI goal of reaching all children by 1990, representing not only a setback for EPI, but also a threat to WHO's aspirations for achieving health for all by the year 2000. Reaffirmation of national commitment and intensification of programme activities are needed, and the Global Advisory Group endorsed the following five-point action programme as a guide for national and international efforts for the remainder of the decade:
FIVE-POINT ACTION PROGRAMME

(1) **Promote the Expanded Programme on Immunization (EPI) within the context of primary health care:**

- develop mechanisms to enable the community to participate as an active partner in programme planning, implementation and evaluation, providing the technical and logistical resources to support these functions; and

- deliver immunization services with other health services, particularly those directed towards mothers and children, so that they are mutually supportive.

(2) **Invest adequate human resources in EPI:** Lack of these resources in general and lack of management skills in particular represent the programme's most severe constraints. Capable senior and middle-level managers must be designated and given authority and responsibility to carry out their tasks. They require training, not only to be effective with respect to EPI, but also to contribute to the understanding and strengthening of the primary health care approach. Reasons for low motivation and performance in the areas of field supervision and management need to be identified in order that appropriate measures can be taken to encourage managers to visit, train, motivate and monitor the performance of those for whom they are responsible.

(3) **Invest adequate financial resources in EPI:** For the programme to expand to reach its targets, current levels of investment in EPI, estimated now at US$ 72 million per year, must be doubled by 1983 and doubled again by 1990 when a total of some US$ 300 million (at 1980 value) will be required annually. Over two-thirds of these amounts must come from within the developing countries themselves, the remaining one-third from the international community.

(4) **Ensure that programmes are continuously evaluated and adapted so as to achieve high immunization coverage and maximum reduction in target-disease deaths and cases:** Such adaptation depends on the development of adequate information and evaluation systems. By the end of 1985 at the latest, each country should be able to:

- estimate reliably immunization coverage of children by the age of 12 months with vaccines included in the national programme;

- obtain timely and representative reports on the incidence of EPI target diseases included within the national programme; and

- obtain information on the quality of vaccine so that it is known that the vaccines employed for EPI meet WHO requirements and are potent at the time of use.

In addition, countries should promote the use of periodic programme reviews by multidisciplinary teams comprising national and outside staff to ensure that operational problems are identified and that a wide range of experience is reflected in the recommendations which are made.

(5) **Pursue research efforts as part of programme operations:** The objectives should be to improve the effectiveness of immunization services while reducing their costs and to ensure the adequate supply and quality of vaccines. Specific concerns include the development of approaches for delivering services which engage the full support of the community, the improvement of methods and materials relating to sterilization and the cold chain, the acquisition of additional knowledge concerning the epidemiology of the target diseases, further development of appropriate management information systems, and further improvement in the production and quality control of vaccines which are safe, effective and stable.

1 Subsequently annexed to resolution WHA35.31.
3.3 This action programme is presented to the Executive Board for review in the hope that, after modification as appropriate, it might be endorsed and transmitted to the World Health Assembly for discussion and action.

3.4 The Global Advisory Group believes that, if countries accept the achievements of EPI as a principal indicator of the success of their strategy to achieve health for all by the year 2000, and if they will address current programme constraints through the action programme, the goal of providing immunization for all children of the world can be attained by 1990.
ANNEX 8

STUDY OF THE ORGANIZATION'S STRUCTURES IN THE LIGHT OF ITS FUNCTIONS:
IMPLEMENTATION OF RESOLUTION WHA33.17

Progress report by the Director-General

1. In May 1981, the Director-General transmitted to the Thirty-fourth World Health Assembly a first progress report on the plan of action for implementing resolution WHA33.17. The report was reviewed in Committee B, and, in summing up this review, the Chairman expressed his conviction that the Committee could trust the Executive Board to continue monitoring the implementation of resolution WHA33.17 along the lines indicated. The Board did so at its sixty-ninth session in January 1982 when it reviewed two reports: one by the Director-General that summarized the action taken by Member States, the Health Assembly, the regional committees and the Executive Board, as well as by the Director-General and the Regional Directors; and one by a working group that had been set up by the Board to study the functions and activities carried out by the Secretariat.

2. As the Director-General's report to the Executive Board indicated, the plan of action for implementing resolution WHA33.17 is being faithfully carried out. Thus, the deliberations of the Health Assembly have acquired greater maturity than ever, as illustrated by its review of the Global Strategy for Health for All and the resources required for it. Greater responsibilities have been delegated to the regional committees and these committees are taking a progressively more active part in the work of the Organization, for example through their reviews of the draft plan of action for implementing the Global Strategy and the material submitted for the Seventh General Programme of Work. The quality and depth of discussions in the regional committees have increased and the analysis of Health Assembly and Board resolutions has expanded and deepened. Nevertheless, these committees still have to face tremendous challenges, such as to provide a forum for inspiring technical cooperation among developing countries (TCDC), with a view inter alia to sharing limited resources. The Executive Board has strengthened its role in giving effect to the policies of the Health Assembly and in providing advice to it. The presentation of issues to the Health Assembly by the Board's representatives and their response to comments by delegates are clear evidence of this. Moreover, the work of the regional committees, the Board and the Health Assembly is much better correlated than in the past.

3. In resolution WHA33.17, the Health Assembly urged Member States to act "in the spirit of the policies, principles and programmes they have adopted collectively in WHO". It would be most valuable to know what progress has been made in this respect, not only concerning what Member States do within their own frontiers, but also in their cooperation with other

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1 See decision WHA35(9).
2 Document A34/15.
5 Document EB69/9.
countries and in their transfer of resources. It is much more difficult to provide information on progress made in implementing this part of resolution WHA33.17 than it is to provide information on activities taking place within the governing bodies and the Secretariat. For example, it would be valuable to know to what extent Member States have been able to strengthen their ministries of health or equivalent bodies so that they can fully assume the role of focal point for the national strategy for health for all; whether they have set up intersectoral mechanisms as required to implement their strategy; how they have fared in bringing ministries of health, universities and medical schools into closer contact; and what steps they have taken to foster the involvement of people in all walks of life as well as that of organized communities. Such information takes time to put together and will be provided to the Health Assembly as it becomes available, particularly in the light of reports by governments to the regional committees on the implementation of their national strategies for health for all.

4. A great deal of effort has been devoted to seeking ways of improving the support provided to Member States by the Secretariat along the lines mentioned in resolution WHA33.17. Thus, a careful review of WHO's functions, organizational structures and staffing in countries, regional offices and headquarters has been carried out and is continuing. One of the most important aspects of this review, which was the very starting point of the study of WHO's structures in the light of its functions, is the relationship between the Secretariat and governments, and in particular the interface between government and WHO action in countries. This was the main focus of the review by the Executive Board Working Group to Study the Functions and Activities carried out by the Secretariat. Thus, the Working Group considered mechanisms for achieving closer involvement of Member States in the work of the Organization and concerned itself in particular with decentralization and greater delegation of authority to the country level. In this context, it proposed ways of strengthening WHO's support to national health authorities, in particular through a broader delegation of authority to the WHO programme coordinator.

5. The Executive Board's deliberations on the two reports mentioned above are reflected in the summary records of the session. The attention of the Health Assembly is drawn to resolution EB69.R10, in which the Board requested the Director-General to strengthen further WHO's technical cooperation with governments in support of national strategies for health for all, taking into account the recommendations of the Executive Board Working Group mentioned above, and taking other appropriate measures as he deems fit. Since then, the Director-General has been holding close consultations in the Global Programme Committee of the Secretariat, which consists of himself, the Deputy Director-General, the Regional Directors and the Assistant Directors-General. He will be holding further consultations shortly after the Thirty-fifth World Health Assembly with a view to taking further action, and, in conformity with resolution EB69.R10, he will continue to keep the support provided by the Secretariat to Member States under constant review. Also in conformity with that resolution, the Regional Directors will keep the regional committees informed of action taken through their reports on the implementation of the regional strategies for health for all, and the Director-General will keep the Executive Board similarly informed through his reports on the implementation of the Global Strategy for Health for All.

\[1\] See document EB69/1982/REC2, pp. 98-118 and 210-211.
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Mr NGO HAC TEAM, First Secretary, Permanent Delegation of Democratic Kampuchea to UNESCO

Alternates
Mrs HUA KANIKA, First Secretary, Permanent Delegation of Democratic Kampuchea to UNESCO

Mr PEH BUNTING, Third Secretary, Permanent Mission of Democratic Kampuchea to the United Nations Office at Geneva and the Other International Organizations in Switzerland

DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

Delegates
Dr KIM Yong Ik, Vice-Minister of Public Health (Chief Delegate)

Mr KWON Sung Yon, Department of External Relations, 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

DEMOCRATIC YEMEN

Delegates
Dr A. S. I. BAMATRAF, Deputy Minister of Public Health (Chief Delegate)

Dr T. SAIFUDDIN MEER, Director, Occupational Health Department, Ministry of Public Health

Mr S. FARES, Minister Plenipotentiary, Permanent Representative of the People's Democratic Republic of Yemen to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

DENMARK

Delegates
Mr H. RASMUSSEN, Minister of the Interior (Chief Delegate)

Mr O. ASMUSSEN, Permanent Secretary, Ministry of the Interior (Deputy Chief Delegate)

Dr S. K. SPØRENSEN, Director-General, National Board of Health²

Alternates
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Mrs E. LUND, Head of division, Ministry of the Interior

Dr N. ROSDAHL, Deputy Director-General, National Board of Health³

Mrs L. E. OLESEN, Head of section, National Board of Health

Mrs J. HERMER, Head of section, Ministry of the Interior

Miss M. -L. LAURSEN, First Secretary, Permanent Mission of Denmark to the United Nations Office and the Other International Organizations at Geneva

¹ Chief Delegate from 10 May.
² Chief Delegate on 3 and 4 May.
³ Chief Delegate from 8 May.
<table>
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<tr>
<th>Country</th>
<th>Advisers</th>
<th>ECUADOR</th>
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<tr>
<td></td>
<td>Mr K. REPSDORPH, Ambassador, Permanent Representative of Denmark to the</td>
<td>Dr N. ROMÁN, Under-Secretary for Public Health, Ministry of Public Health</td>
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<td>United Nations Office and the Other International Organizations at Geneva</td>
<td>(Chief Delegate)</td>
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<td>Dr J. C. SIIM, Technical Director, State Serum Institute</td>
<td>Mr P. AVILA, Director-General, Social Security Institute</td>
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<td>Mr P. THORNT, Secretary to the Minister of the Interior</td>
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<td>Dr A. SØRENSEN, Chief Physician, Copenhagen County Hospital</td>
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<td>Mr E. FIIL, Head of division, Ministry of Foreign Affairs</td>
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<td>Mr E. LASSEN, Adviser, Ministry of Foreign Affairs</td>
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<td>Dr E. L. LAURIDSEN, Adviser, Ministry of Foreign Affairs</td>
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<th>EGYPY</th>
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<td></td>
<td>Dr A. A. WARSAMA, Director of Public Health, Ministry of Public Health</td>
<td>Dr S. ZAKI, Minister of Health (Chief Delegate)</td>
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<td>(Chief Delegate)</td>
<td>Mr A. R. EL REEDY, Ambassador, Permanent</td>
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<td>Representative of the Arab Republic of Egypt to the United Nations</td>
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<td>Dr A. G. KHALLAF, Under-Secretary for Development and Research, Ministry</td>
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<td></td>
<td>Dr H. EL GHAWABY, Director-General, Foreign Health Relations Department,</td>
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<td></td>
<td>Dr R. A. GOMAA, Senior Under-Secretary for Health, Ministry of Health</td>
<td>Dr A. J. COTO, Director-General of Health, Ministry of Public Health</td>
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<td>Mr A. A. EL GAMAL, Under-Secretary for Health, Ministry of Health</td>
<td>(Social Affairs (Chief Delegate)</td>
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<td>Dr L. EL-SAYYAD, Director-General of Maternal and Child Health Care,</td>
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<td>Mr I. A. HASSAN, Counsellor, Permanent Mission of the Arab Republic of</td>
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<td>Miss W. BASSIM, Third Secretary, Permanent Mission of the Arab Republic</td>
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<td>Dr H. G. ABDEL MESSIH, Director of Mental Health, Ministry of Health</td>
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| Country          | Delegates                                                                 |                                                                        |
|                  | Mr E. LASSEN, Adviser, Ministry of Foreign Affairs                      |                                                                        |
|                  | Dr E. L. LAURIDSEN, Adviser, Ministry of Foreign Affairs                |                                                                        |
|                  |                                                                          |                                                                        |
|                  | DOMINICA                                                                 |                                                                        |

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<td>Dr C. MAYNARD, Minister of Education, Health, Sports and Youth Affairs</td>
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<td>Mr F. O. SYMES, Permanent Secretary, Ministry of Education, Health,</td>
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<td>Dr H. L. HERNÁNDEZ, Ambassador, Permanent Representative of the Dominican</td>
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<td>Republic to the United Nations Office and the Other International</td>
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<td>Organizations at Geneva (Chief Delegate)</td>
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<td>Mrs M. ALFONSECA BURSZTEJN-LAVIGNE, Minister Counsellor, Permanent</td>
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<td>Mission of the Dominican Republic to the United Nations Office and the</td>
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<td>Other International Organizations at Geneva (Chief Delegate)</td>
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</table>
Mr J. L. LOVO CASTELAR, Ambassador, Permanent Representative of the Republic of El Salvador to the United Nations Office and the Other International Organizations at Geneva
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Dr J. ENEME OYONO, Director, Malabo General Hospital
Dr B. NGORE MBOYAKO, Deputy Director, Malabo General Hospital

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Dr A. TEDLA, Director, Yekatit 12 Hospital, Ministry of Health

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Dr T. BIUMAIWAI, Permanent Secretary for Health, Ministry of Health

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Dr K. LEPPO, Acting Director, Department of Hygiene and Health Promotion, National Board of Health
Mrs L. OLLILA, Secretary for International Affairs, Ministry of Social Affairs and Health

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Mr I. SALMI, First Secretary, Ministry for Foreign Affairs
Mrs T. RAIVIO, First Secretary (Social Affairs), Permanent Mission of Finland to the United Nations Office and the Other International Organizations at Geneva
Dr K. MÄKELÄ, Director, Finnish Foundation for Alcohol Studies

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Dr J. DANGOUMAU, Director of Pharmacy and Medicines, Ministry of Health

1 Chief Delegate from 5 May.
Members of the Health Assembly

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- Dr. P. LAGET, Chargé de mission, Section of Sciences, Technology and Development, Ministry of External Relations
- Mrs. J. DE LA BATUT, Chargé de mission, Directorate for United Nations and International Organization Affairs, Ministry of External Relations

Alternates

- Mrs. J. DE LA BATUT, Chargé de mission, Directorate for United Nations and International Organization Affairs, Ministry of External Relations

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- Mr. M. BOMBOH, Chef de cabinet of the Minister of Public Health and Population
- Mrs. R. NGOYOU, 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

GERMAN DEMOCRATIC REPUBLIC

Delegates

- Professor L. MECKLINGER, Minister of Health (Chief Delegate)
- Dr. K.-H. LEBENTRAU, Deputy Head, Department of International Relations, Ministry of Health
- Professor F. RENGER, Director, "Theodor Brugsch" Hospital (Charité), Medical Branch, Humboldt University, Berlin

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- Mr. F. WEGMARSHAUS, Deputy head of section, Department of International Relations, Ministry of Health
- Mrs. C. WOLF, Second Secretary, Ministry of Foreign Affairs

GERMANY, FEDERAL REPUBLIC OF

Delegates

- Professor L. VON MANGER-KOENIG, Special Consultant on International Health Affairs to the Federal Minister for Youth, Family Affairs and Health (Chief Delegate)
- Mr. H. VOIGTLÄNDER, Head, International Relations Section, Federal Ministry for Youth, Family Affairs and Health
- Mr. J. WEITZEL, Deputy Head, International Relations Section, Federal Ministry for Youth, Family Affairs and Health

Delegates

- Mr. A. SAMBAT, Minister of Public Health and Population (Chief Delegate)
- Dr. L. ADANDE MENEST, Director-General of Public Health, Ministry of Public Health and Population (Deputy Chief Delegate)
- Mr. M. MBONBA, Director, National Sanitation Service and Urban Hygiene Services

Alternates

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- Dr. B. OBIANG-OSSOUBITA, Medical Inspector-General of Occupational Health and Labour Medicine, Ministry of Labour and Employment
- Dr. A. MBUMBÉ-KING, National Social Security Fund

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- Mr. A. SAMBAT, Minister of Public Health and Population (Chief Delegate)
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German Republic of

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- Mr. J. WEITZEL, Deputy Head, International Relations Section, Federal Ministry for Youth, Family Affairs and Health

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- Mr. M. MBONBA, Director, National Sanitation Service and Urban Hygiene Services

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Dr Christine GAUDICH, Deputy Head, Pharmaceutical Section, Federal Ministry for Youth, Family Affairs and Health
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Delegates
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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

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Delegates
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Mr A. MITSIALES, First Secretary, Permanent Mission of Greece to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Guatemala

Delegates
Dr A. CASTANEDA, Minister of Public Health and Social Welfare (Chief Delegate)
Mrs N. CONTRERAS, Minister Counsellor, Permanent Mission of Guatemala to the United Nations Office and the Specialized Agencies at Geneva (Deputy Chief Delegate)
Dr J. F. ZAMBRONI, Director-General of Health Services, Ministry of Public Health and Social Welfare

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GUINEA

Delegates
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Dr. M. Sylla, Deputy Chief Physician, Donka Hospital Centre

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

Alternate
Dr. P. Mendes

HONDURAS

Delegate

HUNGARY

Delegates
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Dr. L. Sándor, Head of department, Ministry of Health
Mrs. E. Olaszy, First Secretary, Ministry of Foreign Affairs

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Mr. I. Soós, Deputy head of department, Ministry of Health
Dr. L. Éllás, Deputy head of section, Ministry of Health

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Dr. J. Balog, Director, Centre for Health Organization, Planning and Information, Ministry of Health
Mr. L. Kolonics, Deputy head of department, Ministry of Health
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

ICELAND

Delegates
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Mr. H. Gisladason, Counsellor, Ministry for Foreign Affairs
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INDIA

Delegates
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Alternates
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1 Chief Delegate from 9 May.
Mr N. N. VOHRA, Joint Secretary, Ministry of Health and Family Welfare
Dr I. D. BAJAJ, Director General of Health Services, Ministry of Health and Family Welfare
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INDONESIA

Delegates
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Alternate
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Mr H. REKSODIPUTRO, Third Secretary, Permanent Mission of the Republic of Indonesia to the United Nations Office and Other International Organizations at Geneva
Mrs L. HELWINDA, Directorate of International Organizations, Department of Foreign Affairs

IRAQ

Delegates
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Dr A. S. HASSOUN, Director of International Health Affairs, Ministry of Health
Dr S. S. MORKAS, Deputy Director-General for Preventive Medicine, Ministry of Health

Alternates
Dr A. NIAZI, Chief Medical Officer of Health, Governorate of Diala
Dr A. J. ABDUL ABASS, Chief Medical Officer of Health, Governorate of Anbar
Mr M. AL-MUTLAK, Ambassador, Permanent Representative of the Republic of Iraq to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

IRELAND

Delegates
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Mr F. M. HAYES, Ambassador, Permanent Representative of Ireland to the United Nations Office and the Specialized Agencies at Geneva
Mr P. W. FLANAGAN, Assistant Secretary, Department of Health

Alternate
Mr P. McDonagh, First Secretary, Permanent Mission of Ireland to the United Nations Office and the Specialized Agencies at Geneva

Adviser
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Delegates
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Professor B. MODAN, Director General, Ministry of Health (Deputy Chief Delegate)
Dr O. SOFFER, Ambassador, Permanent Representative of Israel to the United Nations Office and the Specialized Agencies at Geneva

Alternates
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Mr U. MANOR, First Secretary, Permanent Mission of Israel to the United Nations Office and the Specialized Agencies at Geneva
Mr D. NEEV, Attaché, Permanent Mission of Israel to the United Nations Office and the Specialized Agencies at Geneva

ITALY

Delegates
Mr R. ALTISSIMO, Minister 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 G. CANAPERIA, President, Italian World Health Centre
Professor F. POCCHIARI, Director, Istituto Superiore di Sanità
Professor D. POGGIOLINI, Director-General of the Pharmaceutical Service, Ministry of Health

IVORY COAST

Delegates
Mr L. COULIBALY, Minister of Public Health and Population (Chief Delegate)
Mr A. TRAORE, Ambassador, Permanent Representative of the Republic of the Ivory Coast to the United Nations Office and the Specialized Agencies at Geneva and Vienna (Deputy Chief Delegate)
Dr I. KONE, Director of International and Regional Relations, Ministry of Public Health and Population

Alternates
Mr K. N'DA, Director of Public Health and Population
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. L. BAUGH, Minister of Health (Chief Delegate)
Mr K. G. A. HILL, Ambassador, Permanent Representative of Jamaica to the United Nations Office and the Specialized Agencies at Geneva
Dr J. A. McHARDY, Chief Medical Officer, Ministry of Health

1 Chief Delegate from 7 May.
2 Deputy Chief Delegate from 7 May.
3 Delegate from 7 May.
Alternates
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Miss C. R. CLAYTON, Minister Counsellor,
Permanent Mission of Jamaica to the
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Miss V. E. BETTON, First Secretary,
Permanent Mission of Jamaica to the
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JAPAN

Delegates
Mr Y. TSUSHIMA, Parliamentary Vice-
Minister for Health and Welfare
(Chief Delegate)
Mr F. SUZUKI, Ambassador Extraordinary and
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United Nations Office and the Other
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(Deputy Chief Delegate)
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Alternates
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Secretariat, Ministry of Health
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Mr Y. SUGANO, Deputy Director, Specialized
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Ministry of Foreign Affairs
Mr S. SUMITANI, First Secretary, Embassy
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Mr A. YAMAMOTO, Senior Assistant Director,
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Dr Y. TERAO, Deputy Director, Planning
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1 Chief Delegate from 6 May.

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Dr H. OWEIS, Director, Health Insurance
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Kenya

Delegate
Dr Z. MALHAS, Minister of Health
(Chief Delegate)
Dr A. A. SHARAYDEH, Assistant Director,
Health Department, Ministry of Health
(Deputy Chief Delegate)
Dr H. OWEIS, Director, Health Insurance
Department, Ministry of Health

Kenya

Alternates
Dr F. M. MUEKE, Deputy Director of
Medical Services, Ministry of Health
Mrs M. GATEI, Nursing Officer, Ministry
of Health

KUWAIT

Delegates
Dr A. R. AL-AWAID, Minister of Public
Health (Chief Delegate)
Mr H. A. DABBAGH, Ambassador, Permanent
Representative of Kuwait to the United
Nations Office in Geneva and the
Specialized Agencies in Switzerland
(Deputy Chief Delegate)
Dr A. AL-SATIF, Head, Division of
International Health Relations and
Deputy Head, Division of Preventive
Medicine, Ministry of Public Health

Kuwait
<table>
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<tr>
<th>Country</th>
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<tr>
<td><strong>Delegates</strong></td>
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<tr>
<td>Mr N. BIZRI, Minister of Public Health</td>
<td>(Chief Delegate)</td>
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<tr>
<td>Dr R. SAADÉ, Director-General, Ministry of Public Health</td>
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<tr>
<td>Mr M. HALLAB, Chief, Sanitary Engineering Department, Ministry of Public Health</td>
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<tr>
<td>Miss R. BIZRI, Chief, Division of International Health Relations, Ministry of Public Health</td>
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<tr>
<td>Mr P. LEHLOENYA, Minister of Health</td>
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<tr>
<td>Mr M. T. THABANE, Permanent Secretary for Health, Ministry of Health</td>
<td>(Deputy Chief Delegate)</td>
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<td>Dr Arabang P. R. MARUPING, Director of Health Services, Ministry of Health</td>
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<tr>
<td>Mrs M. K. BELLEH, Minister of Health and Social Welfare</td>
<td>(Chief Delegate)</td>
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<td>Mrs A. GUANNU, Assistant Minister of Health and Social Welfare</td>
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<tr>
<td>Dr A. WOTORSON, Deputy Chief Medical Officer, J. F. Kennedy Medical Centre, Monrovia</td>
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<tr>
<td>Dr A. HANSON, Director, Institute for Biomedical Research, Robertsfield</td>
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<td>Professor M. LENGHI, Secretary, General People's Committee for Health</td>
<td>(Chief Delegate)</td>
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<td>Dr A. M. ABDULHADI, Under-Secretary of Health, General People's Committee for Health</td>
<td>(Deputy Chief Delegate)</td>
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<td>Mr A. F. NAAS, Counsellor, International Health Department</td>
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<td>Dr S. AZZUZ, Attaché, Permanent Mission of the Socialist People's Libyan Arab Jamahiriya to the United Nations Office and the Specialized Agencies at Geneva</td>
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<td>Mr E. KRIEPS, Minister of Health</td>
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<td>Dr E. J. P. DUHR, Director of Health, Ministry of Health</td>
<td>(Deputy Chief Delegate)</td>
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<td>Mr J. RETTEL, Ambassador, Permanent Representative of the Grand Duchy of Luxembourg to the United Nations Office at Geneva</td>
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<td>Mr J. J. KOHL, Deputy Director of Health, Ministry of Health</td>
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<td>Mrs A. SCHLEDER-LEUCK, Administrative Counsellor, Ministry of Health</td>
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<td>Mr J.-L. WOLZFELD, Deputy Permanent Representative of the Grand Duchy of Luxembourg to the United Nations Office at Geneva</td>
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<td>Professor E. ANDRIAMAMPIHANTONA, Secretary General, Ministry of Health</td>
<td>(Chief Delegate)</td>
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<td>Mr A. M. FETY, Inspector, Ministry of Health</td>
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<td>Mr J. RASOLOFONIRINA, Chief, International Relations Section, Ministry of Health</td>
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### MALAWI

**Delegates**
- Mr. J. T. SANGALA, Minister of Health (Chief Delegate)
- Mr. A. SARA, Deputy Secretary, Ministry of Health (Deputy Chief Delegate)
- Dr. G. LUNGU, Assistant Chief Medical Officer, Ministry of Health

**Alternates**
- Dr. G. TRAORE, National Director of Public Health, Ministry of Public Health and Social Affairs

### MALAYSIA

**Delegates**
- Mr. CHONG Hon Nyan, Minister of Health (Chief Delegate)
- Mr. WONG Yoke Meng, Secretary-General, Ministry of Health (Deputy Chief Delegate)
- Mr. A. K. JAAFAR, Ambassador, Permanent Representative of Malaysia to the United Nations Office and the Other International Organizations at Geneva

**Alternates**
- Dr. L. A. TALIB, Director-General of Health, Ministry of Health
- Mr. TAN Koon San, Deputy Permanent Representative of Malaysia to the United Nations Office and the Other International Organizations at Geneva
- Dr. (Mrs) KEW Siang Tong, Consultant Physician, General Hospital, Kuala Lumpur
- Mr. A. MOHD NAZIR, First 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 National Health Services, Ministry of Health
- Mr. A. S. YOOSUF, Deputy Director of Public Health, Ministry of Health

### MALI

**Delegates**
- Dr. N. TRAORE, Minister of Public Health and Social Affairs (Chief Delegate)
- Dr. S. KEITA, Technical Adviser to the Minister of Public Health and Social Affairs (Deputy Chief Delegate)

### MAURITANIA

**Delegates**
- Dr. Y. DIAGANA, Minister of Health and Social Affairs (Chief Delegate)
- Dr. M. M. HACEN, Director of Health, Ministry of Health and Social Affairs
- Dr. A. DIA, Chief, Psychiatric Service, Nouakchott Hospital

### MAURITIUS

**Delegates**
- Mr. L. SEEWOONARAIN, Permanent Secretary, Ministry of Health (Chief Delegate)
- Dr. D. FAREED, National WHO Programme Coordinator

---

1 Chief Delegate from 6 May.
### 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. M. GARCÍA-VIVEROS, Director-General of Education for Health, Secretariat for Health and Welfare

**Alternate**
- Miss O. GARRIDO-RUIZ, Third Secretary, Permanent Mission of Mexico to the United Nations Office at Geneva and the Other International Organizations in Switzerland

**Adviser**
- Mr. A. SILVA, Secretariat for Health and Welfare

### Monaco

**Delegates**
- Dr. E. BOÉRI, Technical Adviser, Permanent Delegate of the Principality of Monaco to the International Health Organizations (Chief Delegate)
- Mr. D. GASTAUD, Director, Health and Social Affairs

### Mongolia

**Delegates**
- Dr. C. NYAMDORJ, Deputy Minister of Public Health (Chief Delegate)
- Dr. T. Rincindorj, Head, Foreign Relations Department, Ministry of Public Health
- Dr. R. ARSLAN, Foreign Relations Department, Ministry of Public Health

### Morocco

**Delegates**
- Professor R. RAHHALI, Minister of Public Health (Chief Delegate)
- Mr. A. SKALLI, Ambassador, Permanent Representative of the Kingdom of Morocco to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

**Alternates**
- Professor A. JOUHARI-OUARAIÑI, Director of the Office of the Minister of Public Health
- Dr. M. IZDDINE, Senior Physician, Province of El Jadida
- Dr. M. BOUMEHDI, Medical Inspector of the Royal Armed Forces Health Services
- Mr. M. FERAA, Inspector-General, Ministry of Public Health
- Dr. N. FIKRI-BENBRAHIM, Chief, Division of Epidemiology, Ministry of Public Health
- Dr. M. AHMISSE, Chief Physician of Greater Casablanca
- Dr. B. MOUSSA-HOSSEIN, Chief Physician, Province of Tangiers
- Dr. D. RIFKI JAY, Deputy Director, Pasteur Institute of Morocco, Casablanca

**Adviser**
- Mr. O. JENNANE, Secretary-General, Ministry of Public Health
NEPAL

**Delegates**

Professor U. M. MALLA, Member of the National Planning Commission *(Chief Delegate)*

Dr N. L. MASKAY, Director-General of Health Services *(Deputy Chief Delegate)*

Mr K. P. GYAWALI, Acting Chargé d'affaires, Permanent Mission of the Kingdom of Nepal to the United Nations Office and the Other International Organizations at Geneva

**ALTERNATES**

Mr 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, Amsterdam

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 L. J. VAN DEN DOOL, First Secretary, Permanent Mission of the Kingdom of the Netherlands to the United Nations Office and the Other International Organizations at Geneva

Miss A. E. GEVEKE, Department for International Organizations, Ministry of Foreign Affairs

Mr N. W. VISSER, Division of International Affairs, Ministry of Health and Environmental Protection

**ADVISERS**

Mr F. VAN DONGEN, Ambassador, Permanent Representative of the Kingdom of the Netherlands to the United Nations Office and the Other International Organizations at Geneva

Dr H. COHEN, Director-General, National Institute of Public Health, Bilthoven

Dr R. J. H. KRUISINGA, Adviser to the Minister of Health and Environmental Protection and to the Minister of Foreign Affairs

Mr R. J. SAMSON, Chief Director of Health Protection, Ministry of Health and Environmental Protection

Mr A. F. W. KOK, Inspectorate of Mental Health, Ministry of Health and Environmental Protection

NEW ZEALAND

**Delegates**

Mr A. G. MALCOLM, Minister of Health *(Chief Delegate)*

Dr B. CHRISTMAS, Deputy Director-General of Health, Department of Health

Dr J. HOLDEN, Division of Health Promotion, Department of Health

**Alternates**

Mr T. C. O'BRIEN, Ambassador, Permanent Representative of New Zealand to the United Nations Office at Geneva

Mr R. M. RICHARDS, Deputy Permanent Representative of New Zealand to the United Nations Office at Geneva

Mr D. I. WHITE, Second Secretary, Permanent Mission of New Zealand to the United Nations Office at Geneva

Mr M. ARNOTT, Private Secretary to the Minister of Health

NICARAGUA

**Delegates**

Dr I. TERCERO-TALAVERA, Vice-Minister of Health *(Chief Delegate)*

Mr V. SELVA, Ambassador, Permanent Representative of Nicaragua to the United Nations Office and the Other International Organizations at Geneva

Mr C. VEGA, Ambassador, Deputy Permanent Representative of Nicaragua to the United Nations Office and the Other International Organizations at Geneva

**Alternates**

Dr F. CASTELLÓN, Director of International Relations, Ministry of Health

Dr I. GARAY, Counsellor, Permanent Mission of Nicaragua to the United Nations Office and the Other International Organizations at Geneva
### NIGER

**Delegates**
- Mr M. A. DJERMAKOH, Minister of Public Health and Social Affairs (Chief Delegate)
- Dr D. MAGAGI, 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**
- Dr M. S. DJERMAKOH, Director, Office of Pharmaceutical and Chemical Products, Ministry of Public Health and Social Affairs
- Mrs L. AGBESSI, Director of Social Affairs and Maternal and Child Health, Ministry of Public Health and Social Affairs
- Dr D. BAKO, Director of Health, Department of Tahoua, Ministry of Public Health and Social Affairs

### NIGERIA

**Delegates**
- Mr D. C. UGWU, Federal Minister of Health (Chief Delegate)
- Dr G. O. IGEWERE, 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. EMANUEL, Permanent Secretary, Federal Ministry of Health

**Alternates**
- Professor U. SHEHU, National WHO Programme Coordinator
- Dr G. WILLIAMS, Acting Director of Public Health Services, Federal Ministry of Health
- Dr I. O. N. NSOLO, Director of Medical Services and Training, Federal Ministry of Health
- Mr S. A. ILO, Principal Secretary, Federal Ministry of Health
- Professor A. OBUFORIBO, Provost, University of Port Harcourt Teaching Hospital
- Mr O. ADEFOLAJU, Federal Ministry of Health

### NORWAY

**Delegates**
- Professor L. A. HELSE, Minister of Health and Social Affairs (Chief Delegate)
- Dr T. MORK, Director-General of Health Services, Directorate of Health (Deputy Chief Delegate)
- Dr O. T. CHRISTIANSSEN, Deputy Director, Division of Hygiene and Epidemiology, Directorate of Health

**Alternates**
- Mr B. UTHEIM, Counsellor of Embassy, Permanent Mission of Norway to the United Nations Office and the Other International Organizations at Geneva
- Mr J. SYSE, County Health Officer, Tønsberg

**Advisers**
- Dr O. G. AASLAND, Medical Director, Directorate of Alcohol and Drug Problems
- Mr R. Hauge, Director, National Institute for Alcohol Research
- Ms E. HELSING, Executive Officer, Directorate of Health

1 Chief Delegate from 5 May.
2 Deputy Chief Delegate from 5 May.
Mrs M. BERGGRAV, Executive Officer, Norwegian Agency for International Development
Mrs M. QUIVEY, Instructor, Norwegian Advanced School of Nursing
Mrs I. MAGISTAD, Secretary of Embassy, 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 of Preventive Medicine, Ministry of Health (Deputy Chief Delegate)
Dr S. AL-HARAMI, Senior Medical Officer, Ministry of Health

Alternates
Mr M. A. HAMDan, First Secretary, Permanent Mission of the Sultanate of Oman to the United Nations Office at Geneva
Mr I. AL-BASHIR, Administration Expert, Ministry of Health
Dr A. R. FERGANY, Adviser on Health Affairs, Ministry of Health
Dr M. SULTAN, Superintendent, Al Nahdha Hospital

PAKISTAN

Delegates
Dr N. JOGEZAI, Minister for Health and Social Welfare (Chief Delegate)
Professor B. JAZBI, Adviser to the President on Health
Dr I. M. CHAUDHURY, Director-General of Health, Additional Secretary, Ministry of Health and Social Welfare

Alternates
Dr S. HASAN, Deputy Director-General of 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

1 Chief Delegate from 3 to 9 May.

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 A. NAME, Vice-Minister of Health (Chief Delegate)
Mr O. FERRER-ANGUIZOLA, Ambassador, Permanent Representative of Panama to the United Nations Office at Geneva (Deputy Chief Delegate)
Dr E. GONZÁLEZ GÁLVEZ, Head, Department of Preventive and Social Medicine, Ministry of Health

Alternates
Mrs M. SAMUELS, Director of International Affairs, Ministry of Health
Mr C. ALVARADO ACOSTA, Legal Adviser, National Law Commission
Dr R. E. GRAJALES ROBLES, Scientific Counsellor, Permanent Mission of Panama to the United Nations Office at Geneva
Mrs I. AZPURÚA PÉREZ, 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)
Mr G. DUSAVA, Second Secretary, Embassy of Papua New Guinea in Belgium

PARAGUAY

Delegates
Dr A. GODOY JIMÉNEZ, Minister of Public Health and Social Welfare (Chief Delegate)
Dr J. E. ALDERETE ARIAS, Director-General of Health, Ministry of Public Health and Social Welfare
Dr A. ÁVILA ORTIZ, General Administrator, National Medical Centre, Ministry of Public Health and Social Welfare
### PERU

**Delegates**
- Dr. J. FRANCO-PONCE, 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

**Alternates**
- Dr. J. M. SOTELO, Director-General of Health Services, Ministry of Health
- Mr. V. ROJAS, Second 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

**Advisers**
- Mr. C. V. ESPEJO, Attaché, Permanent Mission of the Philippines to the United Nations Office and the Other International Organizations at Geneva

### PHILIPPINES

**Delegates**
- Dr. J. AZURÍN, Minister of Health (Chief Delegate)
- Dr. A. N. ACOSTA, Assistant Minister of Health
- Mr. E. A. MANALO, Third Secretary, Permanent Mission of the Philippines to the United Nations Office and the Other International Organizations at Geneva

**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. S. ORZESZTYNA, Adviser to the Minister of Health and Social Welfare
- Professor W. RUDOWSKI, Director, Institute of Haematology, Warsaw

**Alternate**
- Professor J. JELIASZEWICZ, Chairman, Scientific Council to the Minister of Health and Social Welfare

**Advisers**
- Mrs. B. BITNER, Expert for Cooperation with WHO, Ministry of Health and Social Welfare
- Mr. T. STROJWAS, First Secretary, Permanent Representation of the People's Republic of Poland to the United Nations Office and the Other International Organizations at Geneva

### PORTUGAL

**Delegates**
- Mr. F. REINO, Ambassador, Permanent Representative of Portugal to the United Nations Office and the Other International Organizations at Geneva (Chief Delegate)
- Dr. L. PRADO QUINTINO, Director-General of Health
- Mr. F. PAVILIA-VIEIRA, Minister, Deputy Permanent Representative of Portugal to the United Nations Office and the Other International Organizations at Geneva

**Alternates**
- Dr. L. F. MAGÃO, Assistant Director-General, Office of Health Studies and Planning, Ministry of Social Affairs
- Dr. A. M. COELHO, Assistant Director, National Institute of Health
- Dr. J. da F. BRANDÃO SANTOS, Director, Health Services of Macao
- Mr. F. CABRITA MATIAS, Office of Health Studies and Planning, Ministry of Social Affairs
- Dr. A. BARREIROS E SANTOS, Secretariat of State for Emigration and Portuguese Communities
- Dr. Maria Lucelia MERCÉS DE MELLO, Director, Centre for Treatment of Alcoholics, Coimbra
- Mr. A. PINO DE LEMOS, Counsellor, Permanent Mission of Portugal to the United Nations Office and the Other International Organizations at Geneva

### QATAR

**Delegates**
- Mr. K. M. AL MANA, Minister of Public Health (Chief Delegate)
- Mr. M. S. AL-KUWART, Ambassador, Permanent Representative of the State of Qatar to the United Nations Office and the Other International Organizations in Geneva (Deputy Chief Delegate)
- Mr. M. ABU-ALFAIN, Director, Office of the Minister of Public Health
### Alternates

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<th>Republic</th>
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<tr>
<td>Republic of Korea</td>
<td>Dr. K. Al-Jaber, Deputy Director of Preventive Medicine, Ministry of Public Health</td>
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<td>Dr. A. J. M. Salman, Deputy Director of Primary Health Care, Ministry of Public Health</td>
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<td>Mr. A. Al-Mawlawi, Director of International Relations and Planning, Ministry of Public Health</td>
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<td>Republic of Korea</td>
<td>Mr. Myung Kee Chun, Minister of Health and Social Affairs (Chief Delegate)</td>
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<td>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)</td>
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<td>Dr. Sung Woo Lee, Director General, Bureau of Medical Affairs, Ministry of Health and Social Affairs</td>
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<td>Mr. Sang Ha Han, Director, International Affairs Division, Ministry of Health and Social Affairs</td>
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<td>Mr. Seock Jeong Eom, 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</td>
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### Republic of Korea

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<td>Republic of Korea</td>
<td>Dr. J.-B. Rwasine, Director-General of Pharmacies, Ministry of Public Health (Chief Delegate)</td>
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<td>Dr. B. Muremyangango, Medical Director, Ndera Psychiatric Centre</td>
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### Samoa

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<td>Samoa</td>
<td>Mr. A. Bartolini, Head, Department of Social Security, Hygiene, Health and Welfare (Chief Delegate)</td>
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<td>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 in Switzerland</td>
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<td>Dr. S. Naccarato, Neuropsychiatrist</td>
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### San Marino

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<td>Mr. A. Tiny, Minister of Health and Sports (Chief Delegate)</td>
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<td>Dr. A. S. Marques de Lima, Director of Hospitals, Ministry of Health and Sports</td>
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<td>Dr. J. G. Viegas de Ceita, Director, Malaria Eradication Campaign, Ministry of Health and Sports</td>
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### Sao Tome and Principe

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<td>Mr. M. Bichir, First Secretary, Permanent Mission of the Socialist Republic of Romania to the United Nations Office and the Specialized Agencies at Geneva</td>
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<td>Mr. D. M. Ionescu-Cazana, Attaché, Ministry of Foreign Affairs</td>
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### Saudi Arabia

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<td>Saudi Arabia</td>
<td>Dr. H. A. R. Gezairy, Minister of Health (Chief Delegate)</td>
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<td>Dr. H. S. Dabbagh, Director-General of Preventive Medicine, Ministry of Health</td>
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<td>Dr. A. Al-Marzouky, Director-General of Health Services, Western Region, Ministry of Health</td>
</tr>
</tbody>
</table>
### Alternates

**Dr J. M. AASHI**, Assistant Director of Preventive Medicine, Ministry of Health  
**Dr S. S. ISLAM**, Technical Adviser to the Minister of Health  
**Dr H. KIRIMLY**, Director, Department of International Health, Ministry of Health  
**Dr M. I. AL-KHAWASHKY**, Director-General, Riyadh Central Hospital  
**Dr I. A. SALEH**, Technical Adviser to the Minister of Health  
**Dr U. M. AL-RAZI**, Director, Psychiatric Hospital, Taif  
**Mr N. H. QUTUB**, Secretary for International Conference Affairs to the Minister of Health

### Adviser

**Mr A.-G. A'SHI**, Ministry of Health

#### SENEGAL

### Delegates

**Mr M. DIOP**, Minister of Public Health  
**Mr A. SENE**, Ambassador, Permanent Representative of the Republic of Senegal to the United Nations Office and the Specialized Agencies at Geneva  
**Dr Moustapha TOURE**, President, Commission on Health and Social Affairs

#### Alternates

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**Dr K. S. CHETTY**, Principal Medical Officer, Community Health Division, Ministry of Health

### SIERRA LEONE

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Dr F. T. SIEM TJAM, Director of Health, Permanent Secretary, Ministry of Public Health and Environment

SWAZILAND

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Mr A. PETTERSSON, Under-Secretary of State, Ministry of Health and Social Affairs
Dr Barbro WESTERHOLM, Director General, National Board of Health and Welfare

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Mr I. NYGREN, Head of department, Ministry of Health and Social Affairs

1 Chief Delegate from 6 to 13 May.
2 Chief Delegate on 14 May.

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Dr H. SEILER, Scientific Assistant, Federal Office of Public Health (Deputy Chief Delegate)
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Professor H. SOLMS, Vice-President of the Founding Council, Swiss Foundation for Research on Alcohol
Dr R. MÜLLER, Swiss Institute for Prevention of Alcoholism
<table>
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<tr>
<th>Country</th>
<th>Delegates</th>
<th>Alternates</th>
<th>Advisers</th>
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<tbody>
<tr>
<td>Syria</td>
<td>Dr. G. Rifai, Minister of Health (Chief Delegate)</td>
<td>Mr. J. Al-Baroudi, Minister Counsellor, Permanent Mission of the Syrian Arab Republic to the United Nations Office and the Specialized Agencies at Geneva</td>
<td>Mr. O. Ali, Counsellor, Permanent Mission of the Republic of Trinidad and Tobago to the United Nations Office in Geneva and the Specialized Agencies in Europe</td>
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<td>Dr. M. Ba'ath, Vice-Minister of Health</td>
<td>Mr. M. Sayadi, Counsellor, Permanent Mission of the Syrian Arab Republic to the United Nations Office and the Specialized Agencies at Geneva</td>
<td>Mr. M. G.-A. Lashley, First Secretary, Permanent Mission of The Republic of Trinidad and Tobago to the United Nations Office in Geneva and the Specialized Agencies in Europe</td>
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<td>Dr. W. Haj Hussein, Director of International Relations, Ministry of Health</td>
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<td>Thailand</td>
<td>Professor P. Tuchinda, Under-Secretary of State for Public Health, Ministry of Public Health (Chief Delegate)</td>
<td>Dr. N. Sadudi, Deputy Director-General, Department of Communicable Disease Control, Ministry of Public Health</td>
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<td>Dr. D. Sundaranu, Director, Prasart Neurological Hospital, Department of Medical Services, Ministry of Public Health</td>
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<td>Dr. S. Plianbangchang, Secretary, National Advisory Board for Disease Prevention and Control, Ministry of Public Health</td>
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<td>Mr. S. Dhirakaosal, Second Secretary, Permanent Mission of Thailand to the United Nations Office at Geneva and the Specialized Agencies in Switzerland</td>
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<td>Tonga</td>
<td>Dr. S. Tapa, Minister of Health</td>
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<td>Trinidad and Tobago</td>
<td>Dr. N. Connell, Minister of Health and Environment (Chief Delegate)</td>
<td>Dr. W. S. Naimool, Ambassador, Permanent Representative of the Republic of Trinidad and Tobago to the United Nations Office in Geneva and the Specialized Agencies in Europe (Deputy Chief Delegate)</td>
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<td>Dr. Elizabeth Quamina, Chief Medical Officer, Ministry of Health and Environment</td>
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<td>Togo</td>
<td>Mr. H. Bodjona, Minister of Public Health (Chief Delegate)</td>
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<td>Dr. M. T. Houennassou-Houange, Director General of Public Health, Ministry of Public Health</td>
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<td>Dr. Y. Kassankogno, Chief Physician, General Medicine Service, Kara Regional Hospital</td>
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1 Chief Delegate from 10 May.
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Mr G. TOWO-ATANGANA, Member of the United Nations Council for Namibia
THIRTY-FIFTH WORLD HEALTH ASSEMBLY

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Dr P. BOLECH
Dr J. DEOM

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OBSERVERS INVITED IN ACCORDANCE WITH RESOLUTION WHA27.37

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Mr D. BARAKAT, Permanent Observer of the Palestine Liberation Organization to the United Nations Office at Geneva

Dr A. BASHIR
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Mr Y. YAACOUBIAN
Mrs M. BARAKAT

PAN AFRICANIST CONGRESS OF AZANIA
Mrs H. N. MNGAZA

MEMBERS OF THE SPECIAL COMMITTEE OF EXPERTS APPOINTED TO STUDY THE HEALTH CONDITIONS OF THE INHABITANTS OF THE OCCUPIED TERRITORIES IN THE MIDDLE EAST

Dr Madiou TOURÉ (Chairman)
Dr B. WASISTO
Dr T. IONESCU
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- Mr. I. HOLMSTROM, Liaison Officer, UNDP European Office

**United Nations Conference on Trade and Development**

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**United Nations Industrial Development Organization**

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- Mr. M. POLIEVKTOV, Senior Industrial Development Officer, Pharmaceutical Industries Unit
- Mrs. M. QUINTERO DE HERGLOTZ, Senior Industrial Development Officer, Pharmaceutical Industries Unit

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**Office of the United Nations High Commissioner for Refugees**

- Mr. J. AMUNATEGUI, Chief, Programming, Co-ordination and Evaluation Section
- Mr. S. BODENMAR, Inter-Agency Co-ordination Officer

---

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Mr F. MASSON, IMCO Liaison Officer in Geneva

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Miss A. WEBSTER, IAEA Liaison Office in Geneva

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Mr W. KIRCHBERG
Mr C. DUFOUR, Secretary, Permanent Delegation of the Commission of European Communities to the United Nations Office and the Other International Organizations at Geneva

Commonwealth Secretariat

Professor Sir Kenneth STUART, Medical Adviser
Mr K. S. MURSHID, Assistant Secretary General
Professor P. O. FASAN, Executive Director
Professor A. M. NHONOLI, Regional Health Secretary
Mr K. G. MATHER, Assistant Director, Medical Division

Dr S. SIAGAEV, Head, Health Department

Council for Mutual Economic Assistance

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Mr D. GUNTHORP, Information Officer

Intergovernmental Committee for Migration

Dr C. SCHOU, Senior Medical Officer
Mr H. HABENICHT, Chief, Department of Planning, Liaison and Research

Miss C. M. ROLSTON
Miss A. J. WOODS

1 On 22 May 1982 IMCO's name changed to International Maritime Organization (IMO).
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Dr A. MULLER

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Mr A. McMinn

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Mrs E. VAN DER GRACHT-CARNEIRO

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Mr M. VEUTHEY
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Mr F. SCHMIDT
Mr A. PASQUIER
Mr J.-M. BORNE
Mr J. HOEFLIGER
Mr J. DE CURTEN
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International Diabetes Federation
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International Federation of Chemical, Energy and General Workers' Unions
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Mr V. E. THORPE
Mrs A. RICE

International Federation of Clinical Chemistry
Dr A. DEOM

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| Professor R. SENAUTLT                       | Dr Lili FÜLÖP-ASZÓDI                                                  |
| Dr E. BERTHET                               |                                                                       |
| Mrs A. KAPLUN                               |                                                                       |

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World Psychiatric Association
Dr D. C. SAMITCA

World Veterinary Association
Mr E. AALBERS

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Dr L. ADANDÉ MENEST
Dr Maureen M. LAW
Dr Lidia ORADEAN
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Mr M. DIOP (Senegal)

Vice-Presidents:
Dr M. CALLES (Mexico)
Dr N. JOGEZAI (Pakistan)
Professor L. VON MANGER-KOENIG (Federal Republic of Germany)
Dr C. NYAMDORJ (Mongolia)
Dr A. TARUTIA (Papua New Guinea)

Secretary:
Dr H. MAHLER, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Colombia, Czechoslovakia, Ivory Coast, Lesotho, Malta, Netherlands, Pakistan, Philippines, Sri Lanka, Sudan, Trinidad and Tobago, Zaire.

Chairman: Dr Elizabeth QUAMINA (Trinidad and Tobago)
Vice-Chairman: Dr M. N. NKONDI (Zaire)
Rapporteur: Mr S. F. BORG (Malta)
Secretary: Mr H. SCHLENZKA (Assistant Legal Counsel)

Committee on Nominations

The Committee on Nominations was composed of delegates of the following Member States: Bahrain, Botswana, China, France, Gabon, German Democratic Republic, Guinea-Bissau, Guyana, Honduras, Jordan, Luxembourg, Madagascar, Malaysia, Maldives, Nepal, Nigeria, Peru, Qatar, Swaziland, Union of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, United States of America, Uruguay, Yemen.

Chairman: Dr D. B. SEBINA (Botswana)
Secretary: Dr H. MAHLER, Director-General

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Bulgaria, Cape Verde, China, Comoros, France, Honduras, Jordan, Mauritania, Paraguay, Qatar, Sierra Leone, Trinidad and Tobago, Uganda, Union of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, United States of America.

Chairman: Mr M. DIOP (Senegal), President of the Health Assembly
Secretary: Dr H. MAHLER, Director-General

MAIN COMMITTEES

Under Rule 35 of the Rules of Procedure of the Health Assembly, each delegation was entitled to be represented on each main committee by one of its members.

Committee A

Chairman: Professor A. M. FADL (Sudan)
Vice-Chairman: Professor O. ÖZTÜRK (Turkey)
Rapporteur: Mr M. MBOMBA (Gabon)
Secretary: Mrs I. BRUGGEMANN (Deputy Secretary, Global Programme Committee)

Committee B

Chairman: Mr N. N. VOHRA (India)
Vice-Chairmen: Dr J. FRANCO-PONCE (Peru)
and Dr J. AZURÍN (Philippines)
Rapporteur: Mr R. R. SMIT (Netherlands)
Secretary: Mr I. CHRISTENSEN (Administrative Officer)
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