THIRTY-SEVENTH
WORLD HEALTH ASSEMBLY

GENEVA, 7-17 MAY 1984

RESOLUTIONS AND DECISIONS
ANNEXES

GENEVA
1984
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 (World Bank)
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
UNRO - 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-seventh World Health Assembly was held at the Palais des Nations, Geneva, from 7 to 17 May 1984, in accordance with the decision of the Executive Board at its seventy-second session. Its proceedings are published in three volumes, containing, in addition to other relevant material:

Resolutions and decisions,¹ and list of participants — document WHA37/1984/REC/1
Verbatim records of plenary meetings, and committee reports — document WHA37/1984/REC/2
Summary records of committees — document WHA37/1984/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 1982. 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

WHA37.1 Admission of a new Member: Cook Islands

The Thirty-seventh World Health Assembly

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

Hbk Res., Vol. II (5th ed.), 5.2.1.1 (Third plenary meeting, 8 May 1984)

WHA37.2 Admission of a new Member: Kiribati

The Thirty-seventh World Health Assembly

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

Hbk Res., Vol. II (5th ed.), 5.2.1.1 (Third plenary meeting, 8 May 1984)

WHA37.3 Amendments to the Rules of Procedure of the Health Assembly concerning the election of Members entitled to designate a person to serve on the Executive Board

The Thirty-seventh World Health Assembly,

Considering that the entry-into-force of the amendments to Articles 24 and 25 of the Constitution, increasing the number of members of the Executive Board from thirty to thirty-one, calls for amendments to Rules 102 to 104 of the Rules of Procedure of the World Health Assembly;

ADOPTS the following amendments to the Rules of Procedure of the World Health Assembly:

Rule 102

Replace the present text by the following text:

The General Committee, having regard to the provisions of Chapter VI of the Constitution, to Rule 100, to the suggestions placed before it by Members, and to the candidatures put forward by the members of the General Committee during its meeting, shall by secret ballot draw up a list consisting of at most fifteen Members and at least the same number of Members as the number of seats to be filled. This list shall be transmitted to the Health Assembly at least twenty-four hours before the Health Assembly convenes for the purpose of the annual election of Members to be entitled to designate a person to serve on the Board.

1 See Annex 1.
The General Committee shall recommend in such list to the Health Assembly the Members which, in the Committee's opinion, would provide, if elected, a balanced distribution of the Board as a whole.

Members included in such list other than the Members which, in the Committee's opinion, would provide, if elected, a balanced distribution of the Board as a whole may withdraw their candidatures from the list by notification to the President not later than the closure of working hours on the day preceding the annual election by the Health Assembly of Members to be entitled to designate a person to serve on the Board. Any such withdrawal shall be published in the Journal of the Health Assembly and announced by the President prior to the commencement of voting.

**Rule 103**

Delete the word "ten" in the first sentence.

**Rule 104**

Delete the word "ten" in the second sentence.

WHA37.4 Financial report and audited financial statements for the financial period 1 January 1982 - 31 December 1983, and reports of the External Auditor to the Health Assembly

The Thirty-seventh World Health Assembly,

Having examined the financial report and audited financial statements for the financial period 1 January 1982 - 31 December 1983 and the reports of the External Auditor to the Health Assembly;¹

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

ACCEPTS the Director-General's financial report and audited financial statements for the financial period 1 January 1982 - 31 December 1983 and the reports of the External Auditor to the Health Assembly.

Hbk Res., Vol. II (5th ed.), 6.1.10.3 (Eleventh plenary meeting, 14 May 1984 - Committee B, first report)

WHA37.5 Status of collection of assessed contributions and status of advances to the Working Capital Fund

The Thirty-seventh World Health Assembly

1. NOTES the status, as at 9 May 1984, of the collection of assessed contributions and of advances to the Working Capital Fund, as reported by the Director-General;³

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 1984;

¹ Document A37/8.
² Document A37/28.
4. REQUESTS the Director-General to communicate this resolution to Members in arrears and to draw their attention to the fact that continued delay in payment could have serious financial implications for the Organization.

Hbk Res., Vol. II (5th ed.), 6.1.2.4 (Eleventh plenary meeting, 14 May 1984 - Committee B, first report)

WHA37.6 Members in arrears in the payment of their contributions to an extent which may invoke Article 7 of the Constitution: Chad

The Thirty-seventh World Health Assembly,

Having considered the recommendation of the Executive Board on Chad's proposal for the settlement of its outstanding contributions as contained in the report of the Director-General to the Executive Board on Members in arrears in the payment of their contributions to an extent which may invoke Article 7 of the Constitution;¹

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

2. ACCEPTS the proposal of Chad for the settlement of its outstanding contributions, i.e., to liquidate the outstanding contributions in respect of the period 1980 to 1984 inclusive and totalling US$ 111,775 in ten annual instalments, the first instalment in the amount of US$ 11,182 being paid in 1985 and the remaining nine instalments in the amount of US$ 11,177 each being paid in each of the years 1986 to 1994, subject to the provisions of Financial Regulation 5.6;

3. DECIDES that, if the arrangements specified above are fulfilled by Chad, it will be unnecessary for future Assemblies to invoke the provisions of paragraph 2 of resolution WHA8.13 and that, notwithstanding the provisions of Financial Regulation 5.8, payment of the 1985 instalment of the contribution for the financial period 1984-1985 and contributions for subsequent periods shall be credited to the financial period concerned;

4. REQUESTS the Director-General to communicate this resolution to Chad.

Hbk Res., Vol. II (5th ed.), 6.1.2.4 (Eleventh plenary meeting, 14 May 1984 - Committee B, first report)

WHA37.7 Members in arrears in the payment of their contributions to an extent which may invoke Article 7 of the Constitution

The Thirty-seventh World Health Assembly,

Having considered the report of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-seventh 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 Comoros and Romania are in arrears to such an extent that it is necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether or not the voting privileges of these Members should be suspended;

1. EXPRESSES serious concern at the number of Members which in recent years have been subject to Article 7 of the Constitution;

2. DECIDES not to suspend the voting privileges of Comoros and Romania;

3. URGES these Members to intensify efforts in order to regularize their position;

¹ Document EB73/37.
² Document A37/10.
4. CONSIDERS that in future years the Health Assembly should decide to suspend the voting rights of Members subject to Article 7 of the Constitution as a matter of course, unless in a particular case there are exceptional circumstances justifying the retention of the right to vote which have been communicated by the Member concerned;

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

Hbk Res., Vol. II (5th ed.), 6.1.2.4 (Eleventh plenary meeting, 14 May 1984 - Committee B, first report)

WHA37.8 Assessment of Saint Vincent and the Grenadines

The Thirty-seventh World Health Assembly,

Noting that Saint Vincent and the Grenadines, 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 2 September 1983;

Noting that the United Nations General Assembly, in resolution 37/125, established the assessment of Saint Vincent and the Grenadines at the rate of 0.01% for the years 1983 to 1985;

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 Saint Vincent and the Grenadines shall be assessed at the rate of 0.01% for the second year of the financial period 1982-1983 and for future financial periods;

(2) that Saint Vincent and the Grenadines' assessment relating to the year 1983 shall be reduced to one-ninth of 0.01%.

Hbk Res., Vol. II (5th ed.), 6.1.2.2 (Eleventh plenary meeting, 14 May 1984 - Committee B, first report)

WHA37.9 Assessment of Antigua and Barbuda

The Thirty-seventh World Health Assembly,

Noting that Antigua and Barbuda, 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 12 March 1984;

Noting that the United Nations General Assembly, in resolution 37/125, established the assessment of Antigua and Barbuda at the rate of 0.01% for the years 1983 to 1985;

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 Antigua and Barbuda shall be assessed at the rate of 0.01% for 1984-1985 and future financial periods;
RESOLUTIONS AND DECISIONS

(2) that the instalment of the 1984-1985 assessment which relates to the year 1984 shall be reduced to one-third of 0.01%.

Hbk Res., Vol. II (5th ed.), 6.1.2.2 (Eleventh plenary meeting, 14 May 1984 - Committee B, first report)

WHA37.10 Assessment of the Cook Islands

The Thirty-seventh World Health Assembly,

Noting the admission of the Cook Islands to membership in the Organization;

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

DECIDES:

(1) that the Cook Islands shall be assessed for 1984-1985 and future financial periods at a rate to be fixed by the Health Assembly, as and when an assessment rate for this country has been established by the United Nations General Assembly;

(2) that the Cook Islands shall be assessed at the provisional rate of 0.01% for 1984-1985 and future financial periods, to be adjusted to the definitive assessment rate when established by the Health Assembly;

(3) that the instalment of the 1984-1985 assessment which relates to the year 1984 shall be reduced to one-third of 0.01%.

Hbk Res., Vol. II (5th ed.), 6.1.2.2 (Eleventh plenary meeting, 14 May 1984 - Committee B, first report)

WHA37.11 Assessment of Kiribati

The Thirty-seventh World Health Assembly,

Noting the admission of Kiribati to membership in the Organization;

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

DECIDES:

(1) that Kiribati shall be assessed for 1984-1985 and future financial periods at a rate to be fixed by the Health Assembly, as and when an assessment rate for this country has been established by the United Nations General Assembly;

(2) that Kiribati shall be assessed at the provisional rate of 0.01% for 1984-1985 and future financial periods, to be adjusted to the definitive assessment rate when established by the Health Assembly;

(3) that the instalment of the 1984-1985 assessment which relates to the year 1984 shall be reduced to one-third of 0.01%.

Hbk Res., Vol. II (5th ed.), 6.1.2.2 (Eleventh plenary meeting, 14 May 1984 - Committee B, first report)
Assignment of Algeria to the African Region

The Thirty-seventh World Health Assembly,

Having considered the request from the Government of Algeria for the inclusion of that country in the African Region;

RESOLVES that Algeria shall form part of the African Region.

Hbk Res., Vol. II (5th ed.), 4.1.3 (Eleventh plenary meeting, 14 May 1984)

The spiritual dimension in the Global Strategy for Health for All by the Year 2000

The Thirty-seventh World Health Assembly,

Having considered the Director-General's report on the spiritual dimension in the Global Strategy for Health for All by the Year 2000¹ and the recommendation of the Executive Board thereon contained in resolution EB73.R3;

Understanding the spiritual dimension to imply a phenomenon that is not material in nature but belongs to the realm of ideas, beliefs, values and ethics that have arisen in the minds and conscience of human beings, particularly ennobling ideas;

1. THANKS the Director-General for his report and the Executive Board for its recommendation;
2. CONCURS with the reflections contained in the report;
3. NOTES that ennobling ideas have given rise to health ideals which have led to a practical strategy for health for all that aims at attaining a goal that has both a material and non-material component;
4. RECOGNIZES that if the material component of the strategy can be provided to people, the non-material or spiritual one is something that has to arise within people and communities in keeping with their social and cultural patterns;
5. CONSIDERS that the realization of the health ideals that form the moral basis of the goal of health for all by the year 2000 will itself contribute to people's feelings of well-being;
6. RECOGNIZES that the spiritual dimension plays a great role in motivating people's achievement in all aspects of life;
7. AFFIRMS that ennobling ideas have not only stimulated worldwide action for health but have also given to health, as defined in WHO's Constitution, an added spiritual dimension;
8. INVITES Member States to consider including in their strategies for health for all a spiritual dimension as defined in this resolution in accordance with their social and cultural patterns.


Basic plan on priority health needs of Central America and Panama

The Thirty-seventh World Health Assembly,

Informed of the initiative taken by the governments of the countries of Central America and Panama, embodied in the "basic plan on priority health needs" in that subregion, which they have drawn up in concert and are collectively committed to executing;

¹ Document EB73/1984/REC/1, Annex 1.
RESOLUTIONS AND DECISIONS

Considering the special significance of this initiative for social development, for the solution of health problems, and as a link to promote understanding, solidarity and peace among the peoples of Central America and Panama at a particularly difficult juncture in their history;

Noting that this initiative is in keeping with the principles of solidarity and cooperation that guide WHO's activities aimed at the attainment of the goal of health for all;

1. CONGRATULATES the governments of the countries of Central America and Panama on this initiative;

2. EXPRESSES its full support for the initiative and the measures for implementing it properly;

3. INVITES Member States to support the initiative effectively and to the fullest extent possible;

4. RECOMMENDS that the Director-General take appropriate action and seek all possible means of supporting the implementation of activities aimed at ensuring the success of the initiative;

5. REQUESTS the Director-General to submit a report on the matter to the Thirty-ninth World Health Assembly.


WHA37.15 Implementing the Strategy for Health for All

The Thirty-seventh World Health Assembly,

Noting with satisfaction the decisions taken by a group of Member States - the non-aligned and other developing countries - concerning the implementation of the Strategy for Health for All by the Year 2000;¹

Recognizing the importance of the decisions adopted by the non-aligned and other developing countries in their resolutions on:

(i) implementation of the Strategy for Health for All by the Year 2000;

(ii) technical cooperation among developing countries to attain the goal of health for all by the year 2000;

1. CONGRATULATES the non-aligned and other developing countries on their continuing political commitment and vigorous efforts to attain the goal of health for all;

2. REQUESTS the Director-General to continue to mobilize support for these and other Member countries for the implementation of their strategies for achieving health for all, and for technical cooperation among them, and to report periodically to the Health Assembly on the progress achieved.


WHA37.16 Technical cooperation among developing countries in support of the goal of health for all

The Thirty-seventh World Health Assembly,

Reaffirming the conviction that technical cooperation among developing countries (TCDC) constitutes an important vehicle for health development and for the implementation of national health strategies;

¹ See Annex 2.
Bearing in mind the resolutions of the United Nations General Assembly encouraging technical cooperation among developing countries, and its endorsement of the Declaration and the Plan of Action of the United Nations Conference on Technical Cooperation among Developing Countries, held in Buenos Aires in 1978;

Recalling resolution WHA30.43 which called on all countries to collaborate in the achievement of the goal of health for all by the year 2000, and resolution WHA32.30 endorsing the Alma-Ata Declaration of the WHO/UNICEF International Conference on Primary Health Care;

Taking into account resolution WHA31.41, calling for the strengthening of technical cooperation among developing countries and active collaboration between WHO and the developing countries in the promotion of such cooperation;

Taking note of resolution WHA35.24, congratulating the non-aligned and other developing countries on their expression of political commitment to the goal of health for all;

Noting with satisfaction the adoption by the ministers of health of non-aligned and other developing countries of a medium-term programme on TCDC for health for all (1984-1989) and an initial plan of action on TCDC for health for all (1984-1985), as a contribution by developing countries towards the implementation of the Seventh General Programme of Work;

1. WELCOMES the launching by non-aligned and other developing countries of the medium-term programme (1984-1989), together with the initial plan of action (1984-1985), being convinced that these initiatives will contribute to reinforcing the implementation of national health strategies;

2. CALLS UPON all Member States to give every possible support to this programme and plan of action and to any other relevant programmes and activities based on TCDC, and to make optimal use of WHO resources, particularly at the country level, for carrying out TCDC activities;

3. ESPECIALLY CALLS UPON the developed countries to continue to provide the developing countries, particularly the least developed among them, with technical cooperation and financial resources through bilateral and multilateral channels, including WHO, to assist in carrying out these programmes;

4. EMPHASIZES in this connection the importance of reinforcing multilateral institutionalized cooperation within the framework of priorities fixed by the developing countries and including cooperation among these countries;

5. REQUESTS the Director-General to support these programmes, drawing upon the technical and financial means at his disposal, and to mobilize technical and financial support for the medium-term programme, the initial plan of action and other TCDC programmes and activities, by strengthening collaboration with other components of the United Nations system and with other international organizations.

Hbk Res., Vol. II (5th ed.), 1.2.2.1; 1.1 (Twelfth plenary meeting, 15 May 1984 - Committee A, first report)

WHA37.17 Monitoring progress in implementing strategies for health for all by the year 2000

The Thirty-seventh World Health Assembly,

Reaffirming resolutions WHA30.43, WHA34.36 and WHA35.23 concerning the policy, strategy and plan of action for attaining the goal of health for all by the year 2000;

Recalling resolution WHA33.17 concerning the concentration of the Organization's activities on support for the attainment of this goal;

See Annex 3.
Noting that the attainment of the goal of health for all by the year 2000 is intimately related to socioeconomic development and commitment to and the preservation of world peace;

Recognizing the determination of all countries to contribute fully to achieving the goal of health for all through reinforcement of individual and collective self-reliance, of which technical cooperation among developing countries is an essential element;

Aware that cooperation among all countries and support by developed countries and international organizations, based on the principles of a new international economic order, can significantly contribute to a more rational use of available resources;

Recognizing that monitoring and evaluation are fundamental elements of the managerial process required for the implementation of the strategies, and that the commitment and courage of Member States and a spirit of mutual trust among them are essential for the effective implementation of the Strategy for Health for All;

Mindful that only three-quarters of the Member States submitted progress reports in due time on the implementation of their national strategies;

Noting the progress made thus far in the implementation of the Strategy, but also being aware of the magnitude of the overall task and the relatively short period left to achieve the collectively agreed goal of health for all by the year 2000;

1. **URGES Member States:**

   (1) to accelerate the reorientation and the modifications of health systems towards primary health care, further strengthen the managerial capacity of their health system, including the generation, analysis and utilization of the information needed, and emphasize continuing education of health personnel to support their health management process;

   (2) to accord the highest priority to and assume full responsibility for the continuing monitoring and evaluation of their strategies, individually as part of their managerial process for national health development, and collectively in a spirit of mutual trust in order to identify jointly factors which contribute to or impede the implementation of the Strategy;

   (3) to further refine and update as necessary their national strategies and plans of action for health for all, with clearly defined objectives and targets and appropriate allocation of resources, and apply corrective measures required for accelerating the pace of implementation of their national strategies;

   (4) to promote the importance of multisectoral approaches and their linkages to achieve health for all;

   (5) to pay attention to the planning and evaluation of health manpower development programmes consonant with the needs of their health systems;

   (6) to accelerate efforts to mobilize national and external resources in support of activities that are essential to the implementation of the strategies, ensuring that these resources are adequately directed towards underserved and socially and geographically disadvantaged groups;

   (7) to use WHO's resources optimally, directing them to the mainstream of activities required to implement, monitor and evaluate the national strategy;

   (8) to consider the desirability of enacting health legislation incorporating the basic principles of health for all;

2. **URGES the regional committees:**

   (1) to give increased attention to the review and analysis of the findings of the monitoring and evaluation of national strategies by Member States in the region;
(2) to identify factors and issues facilitating or impeding the implementation of national strategies in the region and promote the required action to foster positive factors and to resolve impeding issues;

(3) to stress the importance of mutual cooperation among Member States in this process;

(4) to carry out a first evaluation of the regional strategy in 1985 in keeping with the plan of action for implementing the Global Strategy for Health for All;

3. REQUESTS the Executive Board:

(1) to continue to monitor actively the progress in implementing the Global Strategy, identifying issues and areas requiring action by Member States individually and collectively;

(2) to participate actively in the Organization's efforts to support the Member States in the implementation of national strategies as well as the monitoring and evaluation activities;

(3) to carry out a first formal evaluation of the Global Strategy and submit its report thereon to the Thirty-ninth World Health Assembly in 1986, in keeping with the plan of action;

4. REQUESTS the Director-General:

(1) to focus further the resources of the Organization on the acceleration and improvement of the implementation of the Strategy for Health for All;

(2) to ensure the provision of intensive, appropriate and targeted support to Member States for the implementation, monitoring and evaluation of the Strategy, especially in countries where the needs are greatest and which are ready for it;

(3) to call upon the developed countries to provide urgent and appropriate technical and economic support to developing countries on a bilateral basis or through WHO, other United Nations agencies and international organizations;

(4) to intensify technical cooperation with Member States in order to strengthen their managerial capacities, including monitoring and evaluation and the related generation, analysis and use of supporting information;

(5) to take steps to review the global indicators and to further develop practical tools for the measurement of these indicators to help Member States in their monitoring of progress towards the targets of the Strategy;

(6) to further strengthen collaboration within the United Nations system and with other intergovernmental, nongovernmental and voluntary organizations in their respective fields of competence to provide countries with technical and financial support for the attainment of the goal of health for all.

Hbk Res., Vol. II (5th ed.), 1.1

(Welfare plenary meeting, 15 May 1984 - Committee A, first report)

WHA37.18 Prevention and control of vitamin A deficiency and xerophthalmia

The Thirty-seventh World Health Assembly,

Recalling resolutions WHA22.29, WHA25.55 and WHA28.54 on the prevention of blindness;

Recognizing the continuing great human suffering, and the considerable burden to both the individual and to society that is caused by nutritional blindness;

Considering that, in Asia alone, more than ten million children are affected by vitamin A deficiency and xerophthalmia, that more than one million of these become blind
every year, that as many as 70% of this number die in the weeks immediately following the onset of blindness, and that the remainder are permanently blind;

Conscious that even mild cases of vitamin A deficiency and xerophthalmia contribute to increased morbidity and mortality in young children in many developing countries;

Considering that vitamin A deficiency and xerophthalmia are highly prevalent in Africa, Asia and the Western Pacific, and in limited areas of the Americas;

Aware that safe, effective and relatively inexpensive techniques exist to control vitamin A deficiency and xerophthalmia, in particular through increased consumption of local foodstuffs rich in provitamin A, periodic mass distribution of large doses of vitamin A, and the fortification of certain foods;

1. THANKS the Director-General for the updated information on selected global and regional trends in nutritional status and related indicators included in his report;¹

2. URGES all Member States to give high priority to the prevention and control of vitamin A deficiency and xerophthalmia wherever these problems exist through appropriate nutritional programmes as part of primary health care;

3. REQUESTS the Director-General:

   (1) to give all possible support to Member States, as and when requested, in assessing the most appropriate approaches, in the light of national circumstances, needs and resources, to preventing and controlling vitamin A deficiency and xerophthalmia;

   (2) to collaborate with Member States in the monitoring of the incidence and prevalence of vitamin A deficiency and xerophthalmia;

   (3) to prepare suitable materials, for adaptation and use at the national level, for training health and development workers in the prevention of vitamin A deficiency - particularly through education in nutrition and by promoting the production of local foodstuffs rich in provitamin A - and in its early identification and treatment;

   (4) to coordinate with other intergovernmental organizations, and appropriate nongovernmental organizations, the launching and management of intensive and extensive international action to combat vitamin A deficiency, including the mobilization of financial and other resources required for such actions;

   (5) to report to a future Health Assembly on progress in this area.

Hbk Res., Vol. II (5th ed.), 1.16.15; 1.11.1 (Thirteenth plenary meeting, 16 May 1984 - Committee A, second report)

WHA37.19 Real Estate Fund and headquarters accommodation

The Thirty-seventh World Health Assembly,

Having considered resolution EB73.R5 and the report of the Director-General² on the status of projects financed from the Real Estate Fund and the estimated requirements of the Fund for the period 1 June 1984 to 31 May 1985;

Noting the additional information provided by the Director-General concerning progress in the construction of a building to house the kitchen and restaurant at headquarters, as authorized by the Thirty-sixth World Health Assembly in resolution WHA36.17, and the restoration of the structural safety of the eighth floor of the main headquarters building;

¹ See Annex 5.
² Document EB73/1984/REC/1, Annex 2.
Noting also the status of the funding of the completed extension to the headquarters facilities authorized by the Thirty-fourth World Health Assembly in resolution WHA34.10; Recognizing that certain estimates must necessarily remain provisional because of the fluctuation of exchange rates;

1. AUTHORIZES the financing from the Real Estate Fund of the expenditures summarized in part V of the Director-General's report, at the estimated cost of US$ 1 598 000;

2. APPROPRIATES to the Real Estate Fund, from casual income, the sum of US$ 805 000.

Hbk Res., Vol. II (5th ed.), 6.1.7; 6.3.2 (Fourteenth plenary meeting, 17 May 1984 - Committee B, second report)

WHA37.20 Transfer of the Regional Office for the Eastern Mediterranean

The Thirty-seventh World Health Assembly,

Having considered resolutions WHA35.13 and WHA36.18, other resolutions on this subject, and the report of the Director-General;

1. THANKS the Director-General for his report;

2. REQUESTS the Director-General to continue the implementation of resolution WHA35.13.

Hbk Res., Vol. II (5th ed.), 4.2.5 (Fourteenth plenary meeting, 17 May 1984 - Committee B, second report)

WHA37.21 Restructuring the Technical Discussions

The Thirty-seventh World Health Assembly,

Having considered the Director-General's report on restructuring the Technical Discussions,¹ and the Executive Board's recommendations thereon;

Recognizing that Technical Discussions continue to serve a useful purpose, since they provide an opportunity for participants to exchange views and experience on technical matters of global interest that are directly related to the objectives of the Organization, and constitute a valuable extension of the programme debates held at the Health Assembly itself;

1. DECIDES:

(1) that the Technical Discussions shall be continued and that they shall be held annually;

(2) that future Technical Discussions shall be devoted to subjects crucial to the attainment of health for all by the year 2000;

(3) that the duration of the Technical Discussions shall continue to be one-and-a-half days;

2. REQUESTS the Director-General in future years to try out experimentally alternative arrangements for the organization, scheduling and methods of work of the Technical Discussions, as indicated in the Director-General's report.

Hbk Res., Vol. II (5th ed.), 3.1.4 (Fourteenth plenary meeting, 17 May 1984 - Committee B, second report)

¹ Document EB73/1984/REC/1, Annex 3.
WHAI.22 Operational activities for development

The Thirty-seventh World Health Assembly,

Having considered the Director-General's report on collaboration within the United Nations system on general matters,1 and in particular United Nations General Assembly resolution 38/171, on "Comprehensive policy review of operational activities for development";

Remaining fully cognizant of the concern expressed by Member States in the General Assembly that the operational activities of the United Nations system should be in accordance with the national plans, priorities, and objectives of the recipient countries, and that the multilateral character of such activities should be maintained;

1. ENDORSES the policies and principles reflected in General Assembly resolution 38/171;

2. CONFIRMS that these development policies and principles are being applied in the technical cooperation work carried out between WHO and its Member States within the framework of the Global Strategy for Health for All by the Year 2000;

3. REAFFIRMS the cardinal principle of national determination in the use of resources available through WHO for ensuring national health development in accordance with strategies for attaining health for all by the year 2000.

Hbk Res., Vol. II (5th ed.), 7.1.1 (Fourteenth plenary meeting, 17 May 1984 - Committee B, second report)

WHAI.23 Abuse of narcotic and psychotropic substances

The Thirty-seventh World Health Assembly,

Recalling resolution WHA33.27 on the abuse of narcotic and psychotropic substances, adopted by the Thirty-third World Health Assembly in May 1980, and resolution EB73.R11 on the same subject;

Recognizing the dramatic global increase in abuse of drugs, and particularly cocaine, all the more alarming in that the young are the chief victims of narcotics dependence;

Considering that the efforts made by the various countries to combat and prevent drug dependence have been insufficient and that WHO, as the agency responsible for the peoples' health, has an important role to play in stimulating more effective national efforts;

Noting with satisfaction the development of the WHO global programme on drug dependence;

1. INVITES Member States to implement in its entirety resolution WHA33.27 of May 1980 and to combine their efforts in exploring new methods for prevention and treatment of drug dependence and improving information on this problem;

2. REQUESTS the Director-General:

(1) to seek extrabudgetary resources to permit WHO to strengthen epidemiological surveillance systems in this field;

(2) to continue his action in the spirit of resolution WHA33.27 and report to the Health Assembly on the progress achieved in this sector;

(3) to include this item in the agenda for the Thirty-ninth World Health Assembly in 1986.

Hbk Res., Vol. II (5th ed.), 1.13.4.2 (Fourteenth plenary meeting, 17 May 1984 - Committee B, second report)

1 Document A37/14.
WHA37.24  Health assistance to refugees and displaced persons in Cyprus

The Thirty-seventh 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, WHA34.20, WHA35.18 and WHA36.22;

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

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

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

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

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

Hbk Res., Vol. II (5th ed.), 7.1.4.5 (Fourteenth plenary meeting, 17 May 1984 - Committee B, second report)

WHA37.25  Health and medical assistance to Lebanon

The Thirty-seventh World Health Assembly,

Recalling resolutions WHA29.40, WHA30.27, WHA31.26, WHA32.19, WHA33.23, WHA34.21, WHA35.19 and WHA36.23 on health and medical assistance to 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 1982-1983 and the first quarter of 1984;

Aware that the tragic situation that has arisen from the latest events requires urgent assistance and relief to the persons displaced from their homes and regions;

Noting the health and medical assistance provided by the Organization to Lebanon during 1983-1984;

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

1 Document A37/15.
2 Document A37/16.
2. **EXPRESSIONS** 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 recently reached 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, medical and relief assistance to Lebanon and to allocate for this purpose, as far as 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, and in particular to put into operation the recommendations of the report on the reconstruction of the health services of Lebanon;

6. **CALLS ALSO UPON** Member States to increase their technical and financial support for relief operations and the reconstruction of the health services of Lebanon in consultation with the Ministry of Health and Social Affairs in Lebanon;

7. **REQUESTS** the Director-General to report to the Thirty-eighth World Health Assembly on the implementation of this resolution.

Hbk Res., Vol. II (5th ed.), 1.2.2.3 (Fourteenth plenary meeting, 17 May 1984 - Committee B, second report)

**WHA37.26 Health conditions of the Arab population in the occupied Arab territories, including Palestine**

The Thirty-seventh World Health Assembly,

Mindful of the basic principle established in the WHO Constitution, which affirms 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;

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 people 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 themselves, under Article One thereof, not only to respect the Convention but also to ensure that it was respected in all circumstances;

Recalling United Nations General Assembly resolutions 38/58 of 13 December 1983 and 38/79 of 15 December 1983 and all other United Nations resolutions relative to the questions of Palestine and the Middle East;

Mindful of the struggle that the Palestinian people, led by the Palestine Liberation Organization, their sole legitimate representative, have waged for their rights to self-determination, to return to their homeland and to establish their independent State in Palestine;

Reiterating the support to this struggle expressed in many resolutions of the United Nations and other international institutions and organizations that call for the immediate and unconditional withdrawal of Israel from the occupied Arab territories, including Palestine;
Taking note of the report of the Special Committee of Experts;¹

Considering the right of the peoples to organize for themselves the provision of their own health and social services;

1. ENDORSES resolution WHA36.27 and previous relevant resolutions of the Health Assembly;

2. CONDEMNS Israel for its continuing occupation of the Arab territories, including Palestine, and its continuing arbitrary practices against the Arab population;

3. CONDEMNS Israel for the continued establishment of Israeli settlements in the occupied Arab territories, including Palestine and the Golan, and the illegal exploitation of the natural wealth and resources of the Arab inhabitants in those territories, especially the appropriation of water resources and their diversion for the purpose of occupation and settlement, and demands that the establishment of new settlements be stopped immediately and that those already established be dismantled;

4. DEMANDS an immediate end to occupation, violence and oppression to enable the Palestinian people to exercise its inalienable national rights, which is a prerequisite to the establishment of a health and social system that would include all necessary institutions to meet its needs;

5. CONDEMNS Israel for its policy aiming, as part of its overall plan of annexation of the occupied territories, at making the Arab population dependent on the Israeli health system by paralysing the services in the Arab health and social institutions;

6. CONDEMNS Israel for continuously raising obstacles to the implementation of resolution WHA36.27, sub-paragraph 8(2), which requests the establishment of three health centres in the occupied Arab territories, including Palestine, under the direct supervision of WHO;

7. THANKS the Director-General for his efforts to implement sub-paragraph 8(2) of resolution WHA36.27 and requests that he pursue these efforts until the full implementation of this resolution and submit a report to the Thirty-eighth World Health Assembly;

8. REAFFIRMS the right of the Palestinian people to have its own institutions which provide medical and social services, and requests the Director-General:

(1) to collaborate and coordinate further with the Arab States concerned and with the Palestine Liberation Organization regarding the provision of the necessary assistance to the Palestinian people;

(2) to take suitable steps to ensure WHO participation in the implementation of the programme of action adopted by the International Conference on the Question of Palestine convened in Geneva on 29 August 1983;

(3) to monitor the health conditions of the Arab population in the occupied Arab territories, including Palestine, and report regularly to the Health Assembly;

9. THANKS the Special Committee of Experts for its report 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, both physically and psychologically, and to report to the Thirty-eighth World Health Assembly, in coordination with the Arab States concerned and the Palestine Liberation Organization.

¹ Document A37/13.
Considering resolutions WHA3.8, WHA18.7 and WHA26.32 adopted by the Third World Health Assembly, the Eighteenth World Health Assembly and the Twenty-sixth World Health Assembly respectively, recommending the adoption of certain international standards and units for biological substances;

I

RECOMMENDS

(1) that Member States of the Organization recognize officially the international standards and international reference preparations and units for biological substances enumerated in the two lists annexed to this resolution, which supersede the lists recommended in resolutions WHA3.8, WHA18.7 and WHA26.32;

(2) that these standards and units or their equivalents be cited in the relevant national pharmacopoeias;

(3) that, where applicable, these standards and units or their equivalents be recognized in relevant national regulations;

(4) that in those countries which do not possess a national pharmacopoeia or national standards, when it is necessary that the potency of the product should be stated on the label, such potency be expressed in international units;

II

Considering also the need to make these international biological standards available to Member States in the most expeditious and convenient manner, as a contribution towards enabling an acceptable level of quality of biological substances used in medicine to be achieved;

Recognizing the value and utility to Member States of these international units, as well as of international units defined for a number of international reference preparations of biological substances, in the national control of biological products;

1. AUTHORIZES the Director-General, where necessary for the use of regulatory agencies of Member States, to make additions to or replacements of these international biological preparations, subject in each case to the satisfactory completion of the technical procedures now established of international collaborative studies and assays and under the advice of the members of the Expert Advisory Panel on Biological Standardization or other experts designated to deal with the standardization of particular biological substances;

2. REQUESTS the Director-General to inform Member States periodically when such international biological preparations are established and their international units have been defined;

3. INVITES the Director-General to inquire periodically of Members regarding the use being made of these international standards and other biological preparations in their countries in the control of biological products.

Hbk Res., Vol. II (5th ed.), 1.15.3.1 (Fourteenth plenary meeting, 17 May 1984 - Committee B, third report)

WHА37.28 Liberation struggle in southern Africa: Assistance to the front-line States, Lesotho and Swaziland

The Thirty-seventh World Health Assembly,

Considering that the front-line States and Lesotho continue to suffer from the consequences of armed banditry, political and economic destabilization by the South African racist regime which hamper their economic and social development;

1 See Annex 4.
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Considering that the front-line States and Lesotho have to accept enormous sacrifices to rehabilitate and develop their health infrastructure which has suffered as a result of military destabilization planned, directed and carried out by the South African racist regime;

Considering also resolutions AFR/RC31/R12 and AFR/RC32/R9 of the Regional Committee for Africa, which call for a special programme of health cooperation with the People's Republic of Angola;

Bearing in mind that the consequences of these destabilization activities still force the countries concerned to divert large amounts of financial and technical resources from their national health programmes to defence and reconstruction;

Further considering the support that has been reaffirmed for the front-line States, Lesotho and Swaziland 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. THANKS the Director-General for his report; 1

2. RESOLVES that WHO shall:

   (1) continue to take appropriate and timely measures to help the front-line States, Lesotho and Swaziland solve the acute health problems of the Namibian and South African refugees;

   (2) continue to provide countries which are or have been targets of destabilization by South Africa with health assistance, health personnel, pharmaceutical products and financial assistance for their national health programmes and for such special health programmes as are necessary, as a consequence of the destabilization activities, for the rehabilitation of their damaged health infrastructures;

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

4. REQUESTS the Director-General:

   (1) to make use, when necessary, of funds from the Director-General's Development Programme to help the countries concerned to overcome the problems arising both from the presence of the Namibian and South African refugees and from destabilization activities, as well as for the rehabilitation of their damaged health infrastructures;

   (2) to report to the Thirty-eighth World Health Assembly on the progress made in the implementation of this resolution.

Hbk Res., Vol. II (5th ed.), 1,2.2.2 (Fourteenth plenary meeting, 17 May 1984 - Committee B, third report)

WHA37.29 Emergency health and medical assistance to drought-stricken and famine-affected countries in Africa

The Thirty-seventh World Health Assembly,

Recalling resolution WHA36.29 concerning the drought and famine in Africa;

Recalling the relevant resolutions of the various summit meetings of the Organization of African Unity;

Recalling resolution AFR/RC33/R8 of the Regional Committee for Africa;

1 Document A37/17.
Considering the persistence of the drought and famine in many African countries;

Considering that the drought-stricken countries are unable to overcome the consequences in the short term and must at the same time take preventive measures in preparation for further periods of drought;

Aware that most of the drought-stricken countries in Africa are among the least developed countries;

Noting the continuing efforts by the governments concerned to cope with the drought and its consequences in their countries;

Noting with satisfaction the efforts made by the Secretary-General of the United Nations and the Director-General of WHO to mobilize resources rapidly on behalf of the countries concerned;

1. THANKS the Director-General for his initiatives aimed at providing appropriate support for the countries affected by drought, famine and other natural disasters in Africa;

2. CALLS UPON Member States to continue their support for the countries concerned;

3. REQUESTS the Director-General:
   (1) 'to take the appropriate steps to strengthen the present support mechanisms in collaboration with the relevant agencies of the United Nations system, donor countries, and governmental and nongovernmental organizations in order to improve the support of the international community for the countries affected by drought and famine in Africa, in accordance with resolution WHA36.29;
   (2) to submit a progress report to the Thirty-eighth World Health Assembly on the application of the present resolution.

Hbk Res., Vol. II (5th ed.), 1.2.2.3 (Fourteenth plenary meeting, 17 May 1984 - Committee B, third report)

WHA37.30 Infant and young child nutrition

The Thirty-seventh World Health Assembly,

Recalling resolutions WHA27.43, WHA31.47, WHA33.32, WHA34.22 and WHA35.26, which dealt with infant and young child feeding;

Recognizing that the implementation of the International Code of Marketing of Breast-milk Substitutes is one of the important actions required in order to promote healthy infant and young child feeding;

Recalling the discussion on infant and young child feeding at the Thirty-sixth World Health Assembly, which concluded that it was premature to revise the International Code at that time;

Having considered the Director-General's report,¹ and noting with interest its contents;

Aware that many products unsuitable for infant feeding are being promoted for this purpose in many parts of the world, and that some infant foods are being promoted for use at too early an age, which can be detrimental to infant and young child health;

1. ENDORSES the Director-General's report;

2. URGES continued action by Member States, WHO, nongovernmental organizations and all other interested parties to put into effect measures to improve infant and young child feeding, with particular emphasis on the use of foods of local origin;

¹ See Annex 5.
3. REQUESTS the Director-General:

(1) to continue and intensify collaboration with Member States in their efforts to implement and monitor the International Code of Marketing of Breast-milk Substitutes as an important measure at the national level;

(2) to support Member States in examining the problem of the promotion and use of foods unsuitable for infant and young child feeding, and ways of promoting the appropriate use of infant foods;

(3) to submit to the Thirty-ninth World Health Assembly a report on the progress in implementing this resolution, together with recommendations for any other measures needed to further improve sound infant and young child feeding practices.

WHA37.31 The role of universities in the strategies for health for all

The Thirty-seventh World Health Assembly,

Appreciating the outcome of the Technical Discussions held at the Thirty-seventh World Health Assembly on "The role of universities in the strategies for health for all";

Mindful of the important role assigned to universities and other higher learning institutions, including colleges for postgraduate medical training, in the Global Strategy for Health for All by the Year 2000, and of the significant contribution that the fulfilment of such a role could make to human development and social justice;

Aware of the prestige that universities carry and the influence they have in developing the minds of young people and in preparing them for their role in society as well as in forming public opinion;

Recalling the functions of universities in providing education and training in the field of health and in a wide variety of social, economic and technical disciplines having a bearing on health, as well as their outstanding contributions to research in these areas;

Keeping in mind the growing involvement of universities throughout the world in grappling with social challenges and in providing services to the communities in which they are situated;

Convinced that there is an increased need for collaboration between ministries and other bodies concerned and universities in order to deal adequately with health and related socioeconomic problems;

Appreciating that ministries and other bodies concerned and universities are becoming increasingly aware of the vast untapped resources in the universities that could be mobilized in furtherance of health and socioeconomic development;

1. URGES Member States:

(1) to encourage universities and other higher learning institutions to include the social and technical concepts of health for all in the education and training of all categories of students and postgraduates and to acquaint the general public with these concepts;

(2) to support universities in orienting the education and training of workers in health and related fields towards the attainment of health for all;

(3) to involve appropriate faculties in universities, wherever applicable, in the preparation of policies for health for all and in the formulation and implementation of strategies to give effect to these policies;
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2. INVITES universities throughout the world:

(1) to ensure that students and postgraduates in all faculties are adequately acquainted with the goal of health for all by the year 2000 and actively support the measures for attaining it;

(2) to provide the kind of education and training for students and postgraduates in the health and related disciplines that will prepare them technically and attune them socially to meet the health needs of the people they are to serve;

(3) to conduct biomedical, epidemiological, technological, social, economic and behavioural research required to prepare and carry out strategies for health for all;

(4) to offer to increase their collaboration with relevant ministries and other bodies for the preparation of policies and formulation, implementation and evaluation of strategies for health for all;

(5) to place themselves at the disposal of communities to the maximum of their capacity for the promotion of health and provision of health care;

(6) to participate in creating awareness in the general public of the action people can take to promote their health and the health of the communities in which they live;

3. REQUESTS the Director-General:

(1) to publish a report on the Technical Discussions and ensure its wide distribution among relevant ministries, universities, other institutions of higher education, and other interested parties;

(2) to ensure in all appropriate forums WHO's advocacy of the proper role of universities in the strategies for health for all and of the related collaboration required between ministries and other bodies concerned and universities;

(3) to provide ministries and other bodies concerned and universities with information that will facilitate the assumption by universities of their role in strategies for health for all;

(4) to support ministries and other bodies concerned, on request, in increasing the involvement of universities in national health development efforts;

(5) to collect and disseminate information on the involvement of universities in the strategies for health for all and on joint endeavours of ministries and other bodies concerned and universities to this end;

(6) to establish the necessary mechanisms at headquarters and regional levels to ensure that all appropriate actions are taken, coordinated, monitored and evaluated;

(7) to carry out the above within available resources, and to report on developments in his biennial reports to the Health Assembly.

Hbk Res., Vol. II (5th ed.), 1.8; 1.1 (Fourteenth plenary meeting, 17 May 1984 - Committee A, third report)

WHA37.32 Action Programme on Essential Drugs and Vaccines

The Thirty-seventh World Health Assembly,

Recalling previous resolutions of the Health Assembly on this matter, and in particular resolution WHA35.27, in which the main lines of the action programme on essential drugs for the coming years and the plan of action for 1982 and 1983 were endorsed;

Having reviewed the Executive Board's report on the Action Programme on Essential Drugs and Vaccines;

Satisfied that the programme is making progress along the lines endorsed by the Thirty-fifth World Health Assembly;

Noting with satisfaction that Member States, development agencies, the pharmaceutical industry and a number of other partners are increasingly responding to the challenge of the programme;

Welcoming in particular the close collaboration between WHO and the United Nations Children's Fund in carrying out the programme;

Recognizing at the same time that a number of major issues remain to be resolved;

1. ENDORSES the Executive Board's report;

2. URGES Member States:

   (1) to intensify their action to introduce and implement drug policies along the lines endorsed by the Thirty-fifth World Health Assembly in resolution WHA35.27;

   (2) to intensify training of personnel to achieve the objectives proposed by the programme;

   (3) to strengthen cooperation among themselves for the implementation of the programme;

3. URGES the regional committees:

   (1) to encourage Member States in their region to give support to the programme along the lines endorsed by the Thirty-fifth World Health Assembly;

   (2) to ensure adequate resources in their regional programme budgets to support Member States in their efforts;

   (3) to review periodically progress in implementing the programme in their region and report thereon to the Executive Board;

4. REQUESTS the Executive Board:

   (1) to continue to review closely progress in implementing the programme;

   (2) to study major outstanding issues and define principles for resolving them;

   (3) to report periodically to the Health Assembly on the above;

5. REQUESTS the Director-General:

   (1) to intensify WHO's technical cooperation with Member States that so desire in implementing national drug policies in conformity with the programme;

   (2) to facilitate technical cooperation among countries in carrying out the programme and specific components of it;

   (3) to foster coordinated action, including research, among all partners involved throughout the world in order to ensure the most effective and efficient implementation of the programme;

   (4) to continue to ensure that adequate resources are provided to implement the programme and to attract extrabudgetary funds to the programmes of developing countries;

   (5) to monitor and evaluate the programme on a continuing basis;

   (6) to continue to report periodically to the Executive Board on progress achieved and problems encountered.
WHA37.33 Rational use of drugs

The Thirty-seventh World Health Assembly,

Recalling resolutions WHA24.56 and WHA31.32;

Recognizing the progress achieved in the development of the WHO Action Programme on Essential Drugs and Vaccines, the Organization's programme on drug information and other WHO activities in this field;

Concerned by the high proportion of health budgets spent on drugs in many countries, particularly in developing countries, thereby limiting the remaining funds available for the provision of adequate health care to the whole population through primary health care;

Realizing the problems of inappropriate and excessive prescription and use of drugs;

Aware of the need for further studies, inter alia in clinical pharmacology, to facilitate the improvement of prescription practices, with regard to effects, adverse reactions and the possible interaction of drugs;

Realizing the need for better knowledge of actual drug consumption and prescription practices;

Aware of the importance of training health personnel to ensure the appropriate use and prescription of drugs;

Recognizing the importance of unbiased and complete information about drugs to health authorities, physicians, pharmacy staff, other health workers and the general public;

Aware of the need for better information on drug marketing procedures and practices;

Recognizing the achievement of local drug and therapeutic committees established in several Member States;

Noting with satisfaction the growing interest shown by governments, registration authorities, the pharmaceutical industry, patients' and consumers' organizations and health workers in information about, and the marketing of, drugs;

Convinced of the need for cooperation between all interested parties in order to achieve a more rational use of drugs;

1. URGES Member States:

(1) to support the development and dissemination of unbiased and complete information on drugs;

(2) to collaborate in the exchange of information on the use and marketing of drugs through bilateral or multilateral programmes and WHO;

(3) to strengthen the national capabilities of developing countries in the selection and proper use of drugs to meet their real needs and in local production and quality control, wherever feasible, of drugs;

(4) to intensify action to introduce and implement comprehensive and rational drug policies;

2. REQUESTS the Director-General:

(1) to continue to develop activities at national, regional and global levels aiming at the improvement of use of drugs and of prescription practices and the provision of unbiased and complete information about drugs to the health profession and the public;

(2) (a) to foster the exchange of information among Member States on drugs, including registration and marketing practices;
(b) to review the machinery within WHO concerning the dissemination of unbiased information relevant to the appropriate use of essential and other drugs; and to introduce appropriate improvements therein;

(3) to arrange in 1985 a meeting of experts of the concerned parties, including governments, pharmaceutical industries, and patients' and consumers' organizations, to discuss the means and methods of ensuring the rational use of drugs, in particular through improved knowledge and flow of information, and to discuss the role of marketing practices in this respect, especially in developing countries;

(4) to submit a report on the results of the meeting of experts and the implementation of this resolution to the Thirty-ninth World Health Assembly.

Hbk Res., Vol. II (5th ed.), 1.15.2 (Fourteenth plenary meeting, 17 May 1984 - Committee A, fourth report)
DECISIONS

(1) Composition of the Committee on Credentials

The Thirty-seventh World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Member States: Argentina; Egypt; Ghana; Guyana; Iceland; Indonesia; Ireland; Jordan; Malaysia; Poland; Rwanda; and Senegal.

(First plenary meeting, 7 May 1984)

(2) Composition of the Committee on Nominations

The Thirty-seventh World Health Assembly elected a Committee on Nominations consisting of delegates of the following 24 Member States: Benin; Bulgaria; Burma; China; Costa Rica; Djibouti; Equatorial Guinea; Ethiopia; France; Jamaica; Japan; Mongolia; Nigeria; Peru; Sweden; Syrian Arab Republic; Tunisia; Union of Soviet Socialist Republics; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United States of America; Upper Volta; Venezuela; and Zimbabwe.

(First plenary meeting, 7 May 1984)

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

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

President: Dr G. Soberón Acevedo (Mexico)

Vice-Presidents:

Mr M. P. To Vadek (Papua New Guinea), Dr S. H. Alwash (Iraq),
Dr M. Shamsul Haq (Bangladesh), Mr P. D. Boussoukou-Boumba (Congo),
Dr A. Grech (Malta)

(Second plenary meeting, 7 May 1984)

(4) Election of officers of the main committees

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

COMMITTEE A: Chairman, Dr K. Al-Ajlouni (Jordan)
COMMITTEE B: Chairman, Dr N. Rosdahl (Denmark)

(Second plenary meeting, 7 May 1984)
The main committees subsequently elected the following officers:

COMMITTEE A: Vice-Chairmen, Mr R. Edwards (Canada) and Professor F. Renger (German Democratic Republic);\(^1\)
Rapporteur: Mrs K. M. Makhwade (Botswana)

COMMITTEE B: Vice-Chairmen, Dr E. Yacoub (Bahrain) and Dr B. P. Kean (Australia);
Rapporteur: Dr Sriati da Costa (Indonesia)\(^2\)

(First meeting of Committee A and first and second meetings of Committee B, 8 and 9 May 1984)

(5) Establishment of the General Committee

The Thirty-seventh 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: Botswana; Cameroon; Chile; China; Cuba; France; India; Kenya; Kuwait; Nigeria; Union of Soviet Socialist Republics; United Kingdom of Great Britain and Northern Ireland; United States of America; Uruguay; Yemen; and Zimbabwe.

(Second plenary meeting, 7 May 1984)

(6) Adoption of the agenda

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

(Third plenary meeting, 8 May 1984)

(7) Verification of credentials

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

\(^1\) Dr K.-H. Lebentrau (German Democratic Republic), proposed by the Committee on Nominations as Vice-Chairman, was unable to accept this nomination and Committee A elected Professor F. Renger in his stead.

\(^2\) Mr B. Balakrishnan (India), proposed by the Committee on Nominations as Rapporteur, was unable to accept this nomination and Committee B elected Dr Sriati da Costa in his stead.
Members:

Afghanistan; Albania; Algeria; Angola; Antigua and Barbuda; Argentina; Australia; Austria; Bahamas; Bahrain; Bangladesh; Barbados; Belgium; Benin; Bhutan; Bolivia; Botswana; Brazil; Bulgaria; Burma; Burundi; Cameroon; Canada; Cape Verde; Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Cuba; Cyprus; Czechoslovakia; Democratic Kampuchea; Democratic People's Republic of Korea; Democratic Yemen; Denmark; Djibouti; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Ethiopia; Fiji; Finland; France; Gabon; Gambia; German Democratic Republic; Germany, Federal Republic of; Ghana; Greece; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Ivory Coast; Jamaica; Japan; Jordan; Kenya; Kiribati; Kuwait; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Mauritania; Mauritius; Mexico; Monaco; Mongolia; Morocco; Mozambique; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Romania; Rwanda; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Seychelles; Sierra Leone; Singapore; Solomon Islands; 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 Tanzania; United States of America; Upper Volta; Uruguay; Venezuela; Viet Nam; Yemen; Yugoslavia; Zaire; Zambia; and Zimbabwe.

Associate Member:

Namibia.2

(Fifth, twelfth and fourteenth plenary meetings, 9, 15 and 17 May 1984)


The Thirty-seventh World Health Assembly, after reviewing the Director-General’s report on the work of the Organization in 1982-1983,3 noted with satisfaction the manner in which the Organization’s programme for this biennium had been implemented.

(Tenth plenary meeting, 11 May 1984)

1 Admitted to membership of WHO subject to the deposit of a formal instrument of acceptance of the Constitution.
2 Credentials provisionally accepted.
(9) Reports of the Executive Board on its seventy-second and seventy-third sessions

The Thirty-seventh World Health Assembly, after reviewing the Executive Board's reports on its seventy-second\(^2\) and seventy-third\(^3\) sessions, approved the reports; commended the Board on the work it had performed; and expressed its appreciation of the dedication with which the Board had carried out the tasks entrusted to it. It 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.

(Tenth plenary meeting, 11 May 1984)

(10) Financial Regulations - additional terms of reference governing the external audit of the World Health Organization

The Thirty-seventh World Health Assembly approved the proposed changes in the Financial Regulations with respect to the additional terms of reference governing the external audit of the World Health Organization as contained in Annex 10 to document EB73/1984/REC/1.

(Eleventh plenary meeting, 14 May 1984)

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

The Thirty-seventh World Health Assembly, after considering the recommendations of the General Committee,\(^4\) elected the following as Members entitled to designate a person to serve on the Executive Board: Egypt; Equatorial Guinea; Guinea; Hungary; Indonesia; Ivory Coast; Kenya; Republic of Korea; Thailand; United Kingdom of Great Britain and Northern Ireland; and United States of America. In accordance with Article 25 of the Constitution, Indonesia was elected for a period of one year only.

(Thirteenth plenary meeting, 16 May 1984)

(12) Annual report of the United Nations Joint Staff Pension Board for 1982

The Thirty-seventh 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 1982 and as reported by the Director-General.\(^5\)

(Fourteenth plenary meeting, 17 May 1984)

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1 See document A37/2.
3 Documents EB73/1984/REC/1 and EB73/1984/REC/2.
4 For report of the General Committee, see document WHA37/1984/REC/2.
5 Document A37/19.
(13) Appointment of representatives to the WHO Staff Pension Committee

The Thirty-seventh World Health Assembly appointed the member of the Executive Board designated by the Government of the Republic of Korea as member of the WHO Staff Pension Committee, and the member of the Board designated by the Government of the Ivory Coast as alternate member of the Committee, the appointments being for a period of three years.

(Fourteenth plenary meeting, 17 May 1984)

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

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

(Fourteenth plenary meeting, 17 May 1984)
ANNEXES
ANNEX I

ELECTION OF MEMBERS ENTITLED TO DESIGNATE A PERSON TO SERVE ON THE EXECUTIVE BOARD

[from A37/3 - 2 April 1984]

Report by the Director-General

1. In 1976 the Twenty-ninth World Health Assembly adopted resolution WHA29.38 containing amendments to Articles 24 and 25 of the WHO Constitution. These amendments, which concern an increase by one (from 30 to 31) in the number of members of the Executive Board in order to permit the election from each region of at least three Member States entitled to designate a person to serve on the Board, came into force on 20 January 1984. The amended articles are worded as follows:

Article 24

The Board shall consist of thirty-one persons designated by as many Members. The Health Assembly, taking into account an equitable geographical distribution, shall elect the Members entitled to designate a person to serve on the Board, provided that, of such Members, not less than three shall be elected from each of the regional organizations established pursuant to Article 44. Each of these Members should appoint to the Board a person technically qualified in the field of health, who may be accompanied by alternates and advisers.

Article 25

These Members shall be elected for three years and may be re-elected, provided that of the eleven Members elected at the first session of the Health Assembly held after the coming into force of the amendment to this Constitution increasing the membership of the Board from thirty to thirty-one the term of office of the additional Member elected shall, insofar as may be necessary, be of such lesser duration as shall facilitate the election of at least one Member from each regional organization in each year.

2. The entry into force of these amendments has practical consequences which are brought to the attention of the Health Assembly. Some of these consequences concern the procedures which the Assembly will need to follow in order to conduct the election; others call for amendments to the Rules of Procedure of the Health Assembly.

2.1 Under the provisions of the new Article 24, the Health Assembly should this year no longer elect 10 Member States as in the past, but should elect 11, in order to raise the total number of members of the Board to 31. In order to maintain the membership of the Board at 31 members, elections will need to follow the sequence 11, 10, 10 in each three-year cycle. However, in 1984 (for the reason explained in paragraph 2.3 below) only 10 Member States will be elected for a three-year period, the eleventh Member State being elected for only one year, i.e. until 1985. Thus, there will be 11 seats to be filled in 1985, 10 seats in 1986 and 1987, again 11 seats in 1988, and so on.

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1 See resolution WHA37.3.

2.2 Moreover, in accordance with the provisions of the new Article 24, the Board must contain at least three persons designated by as many Member States from each region. Hitherto each of the Organization's regions has had at least three members of the Board, except one, the South-East Asia Region, which had only two. Accordingly, in order to meet the new constitutional requirements and ensure that the last-named Region has three members of the Board, the Health Assembly should this year elect two Member States instead of one for the South-East Asia Region.

2.3 The question of the duration of the term of office of these two Member States now arises, in view of the provisions of the new Article 25. This Article stipulates that at least one Member State from each regional organization should be elected each year. The term of office of one of the Member States of the South-East Asia Region which has designated a person to serve on the Board, namely Maldives, expires this year (1984). The term of office of the other Member State of this Region, Nepal, expires in two years' time (1986). In order to permit the establishment of regular rotation, the Health Assembly will need as a transitional measure this year only to choose from the two Member States elected from the South-East Asia Region the one for which the term of office will be limited to one year; the normal term of office of three years will apply to the other. Unless there is agreement between the two countries concerned an appropriate solution would be to decide between these two countries by drawing lots. By virtue of this procedure, the seat occupied for one year only will fall vacant in 1985. In 1986 the seat of the member of the Board designated by Nepal will likewise become vacant. In 1987 the seat occupied for a normal period will in turn become vacant, and so on.
ANNEX 2

GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000¹

[A37/INF.DOC./6 - 10 May 1984]

(a) Letter, dated 9 May 1984, from the delegation of India to the President of the Thirty-seventh World Health Assembly

Permanent Mission of India
to the United Nations Offices,
Geneva
9 May 1984

Sir,

I have the honour to transmit herewith two resolutions adopted at the 8th Meeting of the Ministers of Health of Non-Aligned and other Developing Countries held on 9th May, 1984. These resolutions express their determination to implement the Strategy for Health for All by the Year 2000 A.D. This subject is being discussed under agenda item 19 of the Thirty-seventh World Health Assembly.

We would appreciate it if these resolutions could be circulated in the form of an information document of the Thirty-seventh World Health Assembly.

Yours sincerely,

(signed)
B. Shankaranand
Minister of Health
Government of India

(b) Texts of the resolutions

1. IMPLEMENTATION OF THE STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000

The Eighth Meeting of Ministers of Health of Non-Aligned and other Developing Countries,

Keeping in view the essential linkage between health, the quality of life and socioeconomic development;

Recalling the resolution adopted by the Seventh Meeting of Ministers of Health of Non-Aligned Countries on the implementation of the Strategy for Health for All by the Year 2000;²

Reiterating the continuing importance of the decisions of the non-aligned and other developing countries expressed in resolution WHA35.24;

¹ See resolution WHA37.15.
Referring to the Declaration adopted at the Seventh Conference of Heads of State or Government of Non-Aligned Countries, held at New Delhi in March 1983, and its relevant operative paragraphs dealing with the economic action programme in the health sphere;

Noting with satisfaction that the non-aligned and other developing countries have demonstrated their political commitment to implement the Global Strategy for Health for All by the turn of the century through the primary health care approach;

Reaffirming that the attainment of this common goal will depend on the optimal utilization of world resources, a significant part of which is now being spent on the unproductive arms race and military conflicts, which should be diverted to accelerate the processes of socioeconomic development;

Aware of the urgent need to mobilize all possible resources - political, financial, social and technical - to implement the national strategies for achieving the goal of health for all;

Stressing the role of WHO in promoting such a process;

Recognizing that the progress made so far in the implementation of these national strategies is not uniformly satisfactory in all countries;

1. Urges the non-aligned and other developing countries to:
   (a) establish appropriate systems for assessing the strengths and weaknesses of their national health programmes;
   (b) take corrective measures to remove bottlenecks and provide additional inputs, wherever called for;
   (c) carry out country resource utilization reviews to assess the resource position of their health sectors and mobilize both internal and external resources for meeting the shortfalls;
   (d) ensure that adequate resources are earmarked in their national budgets for programmes in the health and health-related sectors;
   (e) allocate an increased proportion of these resources for identified priority programmes of member countries, keeping in view the need to prevent, control and eradicate communicable diseases, reduce infant mortality, improve maternal and child health and develop the human resources for providing primary health care;

2. Calls upon the non-aligned and other developing countries to evolve suitable mechanisms for facilitating technical cooperation among themselves with a view to achieving the desired objectives;

3. Appreciates the efforts of the Director-General to bring WHO programme funding into line with the Global Strategy for Health for All;

4. Requests the Director-General to continue to mobilize financial and technical support to enable the non-aligned and other developing countries to successfully implement their national health strategies.

2. TECHNICAL COOPERATION AMONG THE NON-ALIGNED AND OTHER DEVELOPING COUNTRIES TO ATTAIN THE GOAL OF HEALTH FOR ALL BY THE YEAR 2000

The Eighth Meeting of Ministers of Health of Non-Aligned and other Developing Countries, Recalling the decisions taken at the Fifth, Sixth and Seventh Conferences of Heads of State or Government of Non-Aligned Countries on cooperation among non-aligned and other developing countries in the field of health;
Reaffirming the decisions embodied in the resolution on technical cooperation among the non-aligned and other developing countries adopted at the Seventh Meeting of Ministers of Health of Non-Aligned Countries at Geneva in May 1983;

Mindful of resolutions WHA30.43, WHA34.36, WHA35.23 and WHA35.24 adopted by the World Health Assembly;

Being convinced of the increasing relevance of technical cooperation among non-aligned and other developing countries in attaining the goal of health for all by the year 2000;

Noting the initiatives taken by the World Health Organization, other international organizations and certain regional groups of countries for promoting bilateral as well as multilateral cooperation in the field of health;

Welcoming the steps taken by some countries in offering facilities to other member countries and earmarking specific funds for promoting technical cooperation among themselves;

Aware that WHO should increase its catalytic role in assisting the non-aligned and other developing countries in promoting technical cooperation among themselves;

Recognizing that there is considerable scope for further expanding these activities and programmes at the intercountry, subregional, regional and global levels;

Having considered the medium-term programme (1984-1989) and the initial plan of action (1984-1985) on technical cooperation among developing countries for health for all;

1. Adopts the medium-term programme (1984-1989) and the initial plan of action (1984-1985) on technical cooperation among developing countries for health for all;

2. Calls upon the non-aligned and other developing countries actively to promote technical cooperation among themselves by:

(a) incorporating the approaches contained in the medium-term programme in their national health strategies;

(b) participating actively in the implementation of the initial plan of action (1984-1985);

(c) developing and implementing other relevant programmes and activities that could contribute to the strengthening of technical cooperation among developing countries and the achievement of the social goal of health for all;

(d) establishing suitable intercountry, subregional, regional and global mechanisms for identifying the needs and capabilities of member countries in implementing their national health strategies for technical cooperation among developing countries;

(e) providing technical and financial resources for implementing the mutually agreed programme;

(f) making optimal use of WHO resources, particularly at the country level, for carrying out TCDC activities.

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ANNEX
REPORT ON MONITORING PROGRESS IN IMPLEMENTING STRATEGIES
FOR HEALTH FOR ALL

1. REPORT OF THE EXECUTIVE BOARD

[A37/4 - 5 March 1984]

CONTENTS

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I. INTRODUCTION

1. In 1979, the Thirty-second World Health Assembly launched the Global Strategy for Health for All by the Year 2000, and invited the Member States of WHO to act individually in formulating national policies, strategies and plans of action for attaining this goal, and collectively in formulating regional and global strategies (resolution WHA32.30).

2. The Global Strategy for Health for All by the Year 2000\(^2\) was adopted by the Thirty-fourth World Health Assembly in May 1981 (resolution WHA34.36). When approving the Global Strategy, the Health Assembly also decided to monitor its progress and evaluate its implementation at regular intervals. It requested the Executive Board to prepare a plan of action for the immediate implementation, monitoring and evaluation of the Strategy. It also invited the Member States to formulate or strengthen, and implement, their strategies for health for all accordingly, and to monitor their progress and evaluate their implementation, using appropriate indicators to this end.

3. In May 1982, the Thirty-fifth World Health Assembly approved the Plan of Action for Implementing the Global Strategy for Health for All\(^3\) (resolution WHA35.23). The resolution called on the Member States, the regional committees and the Director-General to fulfil their responsibilities in carrying out the activities devolving on them for implementing and monitoring the Strategy. It further requested the Executive Board to monitor progress in implementing the plan of action in conformity with resolution WHA34.36 and to report to the Health Assembly on progress made and problems encountered.

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\(^1\) See resolution WHA37.17.


4. The Plan of Action calls on the Member States to review, update and formulate as required their national health policies, strategies and plans of action for their implementation, including specific targets wherever possible; to review and reorient their health systems as necessary; to undertake actions which will promote and support the development and implementation of their strategies, including the mobilization of resources; and to introduce a process and establish the necessary mechanisms to monitor and evaluate their strategies, including selection of the indicators to be used for this purpose.

5. It calls on the regional committees to update and adapt the regional strategies as necessary; to consider the possibility of defining regional targets on the basis of national targets; to prepare regional plans of action; and to undertake promotional and supportive actions, including the fostering of intercountry cooperation and mobilization of resources. It also requests the regional committees to decide on indicators to monitor and evaluate the regional strategies; to monitor progress in implementing the regional strategies every two years; and to evaluate the effectiveness of the regional strategies every six years and update them as necessary in relation to the preparation of WHO's General Programme of Work.

6. The Plan of Action also assigns specific action to be taken by the Executive Board, the Health Assembly and the Director-General in support of the implementation of the strategies. The Executive Board is called upon to monitor progress in implementing the Strategy every two years, following the monitoring of progress by the regional committees; to review in intervening years reports on the implementation of the Strategy presented by the Director-General in accordance with resolution WHA34.36; and to evaluate the effectiveness of the Strategy every six years in relation to the preparation of WHO's General Programme of Work, following the evaluation by the regional committees.

7. According to the Plan, the Member States were to submit the first progress report on implementation of their strategies to the regional committees in March 1983, while monitoring of progress in implementing the regional strategies was to be carried out by the regional committees in September 1983. The Executive Board was requested to monitor progress in implementing the Global Strategy in January 1984 and submit a report to the Health Assembly, including recommendations for adjustment of the global Plan of Action as necessary, in May 1984.

8. This global report has been prepared from the six regional reports (which in turn were prepared on the basis of country progress reports) and relevant information from the Secretariat, and thus reflects the overall progress achieved in the implementation of the strategies for health for all at the national, regional and global levels.

9. In view of the relatively short time that has elapsed since the strategies for health for all were launched, it was considered appropriate that countries should concentrate at this stage and in this first progress report on the monitoring of the relevance of their health policies to the attainment of the goal of health for all and on the progress made in implementing them. In assessing progress, the main emphasis has been placed on finding out to what degree strategies have already been formulated and are actually being carried out and on indicating wherever possible reasons or factors which are facilitating or impeding progress. In addition, an effort has been made to collect information, to the extent possible, on the 12 global indicators agreed upon by the Health Assembly.

10. A common framework and format was prepared for the monitoring of national, regional and global strategies. The document, whose basic aim was to enhance monitoring by the countries of progress made in implementing their national strategies, was also intended to enable them to present the results of monitoring in a uniform fashion so that these results could be used to prepare regional and global syntheses. The common framework and format was reviewed and

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1 Documents AFR/RC33/12 (Africa), CD29/24 (the Americas), SEA/RC36/14 (South-East Asia), EUR/RC33/10 (Europe), EM/RC30(83)/5 (Eastern Mediterranean) and WPR/RC34/7 (Western Pacific).

2 Common framework and format for monitoring progress in implementing the strategies for health for all by the year 2000 (document DGO/82.1).
approved by the regional committees in 1982, and Member States were requested to submit their reports to the corresponding regional director by March 1983 so that they could be consolidated at the regional level. The table below shows that about three-quarters of Member States have sent progress reports to their regional office. The consolidated regional reports were then sent to WHO headquarters for the preparation of the global report. The regional committees reviewed their regional reports in September and October 1983; their comments and recommendations have been incorporated in the global report.

Number of progress reports received from Member States, by WHO region

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of reports</th>
<th>Coverage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expected</td>
<td>Received</td>
</tr>
<tr>
<td>Africa</td>
<td>44*</td>
<td>37</td>
</tr>
<tr>
<td>Americas</td>
<td>31</td>
<td>19</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Europe</td>
<td>35</td>
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</tr>
<tr>
<td>Western Pacific</td>
<td>17</td>
<td>12</td>
</tr>
<tr>
<td>All regions</td>
<td>161*</td>
<td>122</td>
</tr>
</tbody>
</table>

* Including 1 Associate Member.

II. PROGRESS AT COUNTRY LEVEL, INCLUDING ANALYSIS OF SELECTED GLOBAL INDICATORS

11. As indicated earlier, at this phase of the monitoring process the emphasis is placed on reviewing the relevance of national health policies to the attainment of the goal of health for all and the progress being made in implementing national strategies with respect to their major thrusts, including the development of appropriate managerial processes to facilitate their implementation.2

Health policies and political commitment

12. The Strategy for Health for All is based on the following fundamental policies: health is a fundamental human right; an equitable distribution of health resources leading to universal access to primary health care and its supporting services is required; emphasis should be on the right and duty of people to participate in their health care; governments have a responsibility for the health of the people, and therefore high-level political commitment is essential; health should be considered as an integral part of development, and the coordinated efforts of many social and economic sectors will be required to achieve health for all.3

13. Countries were asked to examine the relevance of their existing national health policies to the goal of health for all.

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1 In mid-1983 WHO had 160 Members and one Associate Member.
2 Common framework and format for monitoring progress in implementing the strategies for health for all by the year 2000 (document DGO/82.1).
3 Global Strategy for Health for All by the Year 2000, op. cit., section II, para. 9.
14. The responses indicate that a large majority of the countries answering have reviewed their health policies and practically all felt that their policies were geared to the attainment of health for all. In some countries, health policy review was a continuous process for some years even before the Declaration of Alma-Ata, although many others have only recently reviewed and appropriately adjusted their health policies, incorporating the principles of the Alma-Ata Declaration. Several countries have a clause in their constitution ensuring the right to health for every citizen, and most countries endorse the government’s responsibility for the protection of their people’s health.

15. Existing health policies in most countries recognize health as an integral part of development and the importance of coordinated intersectoral action for health. A high level of political support for health in some countries is evident, as reflected in the statements of heads of state, the establishment of high-level interministerial bodies for health, and the incorporation of health policy objectives in socioeconomic development plans. Of the 107 countries which provided information on global indicator 1, 103 answered positively, two stated that a partial endorsement has been received, and only two replied negatively. 1

16. While in principle the existing national health policies conform to the Alma-Ata Declaration and are oriented to the achievement of health for all, they differ in their contents, the means by which they were formulated, and the level of endorsement they have received in the government. In some countries the policies express the need to give greater attention to special groups (such as the aged, or disabled persons) or special geographical groups that are underserved or unserved. Some countries in the European Region have included in the policy provisions the right of individual access to medical care, control of environmental pollution, continuous improvement in living, housing and working conditions, and increased emphasis on medical scientific research. The right of individuals to education and information on health matters and the participation of people as individuals or groups is emphasized. All countries have stressed the strengthening of primary health care and preventive measures for the protection of health of the people.

17. Very few countries have taken specific steps to adopt appropriate legal provisions to give effect to their policies. Most of the developing countries appear to be concerned with the gross inequity in the distribution of health resources. Some countries, particularly the least developed ones in Africa, have commented that they do not have the means to become self-reliant.

18. It is evident that a high level of political sensitization to the goal of health for all has taken place in the countries. National health policies, however, do not indicate how social equity in health will be achieved except in a few countries where special consideration for unserved or disadvantaged groups has been included in socioeconomic development plans.

19. The establishment of national health policies is a continuing element of the health development process and requires some system for the periodic review of existing health policies, the refinement of policy measures, the shifting of priorities and identification of specific goals and objectives for disadvantaged groups, on the basis of information refinements and the progress being achieved. Very few countries have established mechanisms such as an intersectoral council to review progress periodically and to define and promote action in other sectors to support health. Countries will need to refine their policies further, especially to achieve a more equitable allocation of health and health-related resources. Countries where a high-level political commitment has not yet been made will need to do so in the near future.

Formulation of national strategies and plans of action

20. Countries are called upon to review their national health strategies in the light of their health policies, to update or formulate these strategies as necessary to achieve clearly stated objectives and, wherever possible, specific targets, and to indicate broad lines of action to be taken to achieve them. The implementation of these strategies requires the formulation of a well-defined plan for principal actions which need to be undertaken, such as

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1 Global indicator 1 is defined as the number of countries in which health for all has received endorsement as policy at the highest official level.
organization or reorientation of health systems based on primary health care and integration into these health systems of countrywide programmes that deliver appropriate health technology; development of health infrastructure support, including health manpower development; and measures to involve communities. These plans should indicate the time-frame, resource projections and allocations, and responsibilities for the implementation of these actions.¹

21. To assess the level of progress being made in the development of national strategies and plans, governments were requested to report on the status of formulation of their national strategies and plans of action and the extent to which their national health strategies formed an integral part of their national socioeconomic development plan.

22. The majority of countries indicated that they have continuing activities related to the formulation of national strategies. Some have either formulated their national strategies for health for all or are in the process of reviewing and adjusting their national health strategies, incorporating the principles of the Alma-Ata Declaration. A few countries have indicated that their strategies have been within these principles for many years (even before the Alma-Ata Conference) and hence there is no need to adjust them.

23. A few countries have developed long-term plans covering two decades up to the year 2000. Examples of these plans given are: "An outline of health development for the coming two decades" in China, "Strategy and plan of action for achieving health for all Filipinos by the year 2000", "A long-term prospective health plan for the year 2000 as part of the national development strategy in the Republic of Korea", and a "Long-term health development plan" in Indonesia. In most of the countries, however, the plans have been formulated for a medium-term period (five years), generally corresponding to the period of the national socioeconomic development plan. Several countries have also reported that their health plans are an integral part of their socioeconomic development plans. In some countries national plans of action are tentative, awaiting government approval, or are in the process of being formulated. Several have reported that they have not formulated their plans.

24. In most cases, however, the national plans are very general and give overall objectives, emphasize main priority areas such as improvement of community-based services, improvement of the health of specific population groups, or control of certain diseases, and indicate main strategies focusing primarily on the expansion of health systems, with primary health care as the basis. They do not include specific targets, a time-frame or a projection of resources. Specific definitions of the actions and policies proposed and the health implications of alternative strategies are not given adequate consideration.

25. Even where in principle the health plans are an integral part of socioeconomic development plans, the links between national socioeconomic plans and programmes in health and health-related sectors are not clearly defined. Some of the developed countries (European Region) have emphasized plans in other sectors that support health, such as housing, social services, reduction of unemployment, and environmental control. In most countries, however, identification of those aspects of development schemes that can either promote or threaten health has not received adequate attention from economists and health planners.

26. Few countries appear to have adequate planning processes installed as an integral part of management processes for health development. The planning process requires an adequate feedback of information which would permit adjustments, refinement of targets, and allocation of resources. It is evident that in most countries planning processes need to be strengthened and supported by the improvement of health information systems and management training. Suitable methodologies for intersectoral planning are still to be developed and utilized to show the effects of alternative strategies for integrated development programmes.

¹ Global Strategy for Health for All by the Year 2000, op. cit.
Progress achieved in the implementation of national strategies

27. The main thrust of the Strategy for Health for All is the development of the health system infrastructure, based on primary health care, for the delivery of countrywide programmes that reach the whole population. The Strategy involves specific measures to be taken by individuals and families in their homes, by communities, by the health services at the peripheral and supporting levels, and by other sectors. A high degree of community involvement is essential. The goal of health for all cannot be achieved by the health sector alone; coordinated action with other sectors, especially health-related sectors, is therefore crucial. While the Strategy calls for self-reliance of the countries in achieving the goal of health for all, many countries may not yet be in a position to become self-reliant and hence they need to cooperate with other countries and establish effective mechanisms for doing so, including the encouragement of a flow of financial and technical resources from the developed to the developing countries.1

28. Only two years have elapsed since the approval of the Global Strategy, and many countries are in the process of formulating or adjusting their national strategies and formulating plans of action for their implementation. However, the processes for the review and strengthening of health systems to provide health services to a greater number of people have been under way for the past several years. It is thus not too early to review the status of development in the countries of some of the key processes considered crucial to the achievement of the goal of health for all.

Health systems development

29. Countries have recognized that concerted efforts will need to be made to develop health systems of which primary health care is the central function and the main focus, in conformity with the Declaration of Alma-Ata and in line with the recommendations and details concerning primary health care contained in the report of the Alma-Ata Conference.2 The need for wider coverage of services, more inter- and intrasectoral coordination, administrative decentralization, and greater involvement of communities in decision-making and implementation have important implications for the organization of the health systems and their management.

National health systems require the capacity to identify problems and recognize groups of action or priority actions which need to be taken to solve these problems. Where appropriate, existing health services delivery systems will require a systematic review in order to define what mix of the health services delivery system is appropriate to achieve the goal of health for all; what the contents of the services to be delivered and the technologies to be used should be at each level; and what resources - physical, material and human - are appropriate to support each level in order to achieve a well-coordinated infrastructure, starting with individual, family and community care, and continuing with intermediate and central support and referral levels.

30. Countries were asked to provide information on the extent to which they have reviewed and adjusted their health systems to reflect the essential characteristics of such systems based on primary health care, including the necessary health programmes and infrastructures.

31. The reports indicate that several countries have initiated efforts to review their health systems and to define the reorientation needed. Some countries have begun to implement some of the changes, such as reorganization of the central levels of ministries of health and definition of the roles and functions of the intermediate administrative levels, with emphasis on increasing decentralization of authority and responsibilities. A few countries have reviewed their existing public health laws and introduced revisions in support of the changes desired.

32. Several countries have taken steps to define more clearly the levels of health care delivery systems, the linkages, and referral mechanisms. The emphasis in all cases is on strengthening the community-based health services and the corresponding health infrastructures.

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1 Global Strategy for Health for All by the Year 2000, op. cit.
To achieve the latter, many countries have introduced and trained new categories of health workers at the community level or strengthened the role and technical capacity of existing health workers, established informal or formal mechanisms to give more authority to the community and intermediate level health administration, and provided additional physical and financial resources to expand the community-based health services.

33. The need to strengthen managerial capacity in their health systems is recognized by most developing countries and some have initiated efforts in this direction. Examples given are: improvement of health information systems to strengthen monitoring and evaluation processes; coordination of research and reorientation towards priority areas; and improvement of coordination mechanisms at different levels, e.g., establishment of health councils or committees. Very few have actually introduced administrative reforms, including legal measures, to decentralize administrative authority.

34. Some countries, particularly the developed countries, have indicated that there is no need to adjust their existing health systems but rather to shift the emphasis to services outside the hospitals and to priority programmes such as the control and prevention of diseases of concern, the reduction of disability-causing conditions, and the establishment of services to reach underserved areas and disadvantaged or special population groups, especially the elderly and the handicapped. A few have even indicated that their health systems are already in line with the principles of the Alma-Ata Declaration and are achieving good coverage of the population.

35. In general, to summarize from the available reports, a large majority of countries have accepted the need for reorienting their health system and strengthening their managerial capacities, with emphasis on the strengthening and expansion of primary health care services. From the types of approaches taken by the countries, it is clear that, in general, countries have recognized what needs to be done to develop and strengthen their health systems.

36. Reorientation of existing and established health systems is a long-term, complex and dynamic process which requires a continuous feedback of information and, in many areas, trials to define clearly what changes are required and which would be effective or feasible. Countries have not given much information on how these changes are being brought about, what constraints and difficulties are being experienced in bringing about these changes, or how effective some of these changes have been. It is evident therefore that national capabilities for the collection, analysis and utilization of information in support of the managerial process for health development require strengthening. In this area, countries can learn much from each other. There is also a clear need for health services research and simple, pragmatic and effective procedures and methodologies which the countries could develop and utilize in bringing about the desired changes in the health system.

37. Issues concerning the appropriate mix of health technologies, especially for the essential components of primary health care, and a balanced approach to the delivery of these technologies through a well-defined health infrastructure which supports primary health care, are still confronting countries in their efforts to develop their health systems.

**Community involvement**

38. One of the most dynamic factors in the achievement of the goal of health for all is the active involvement of communities in the process of health development and in the promotion and adoption of positive attitudes towards health by the people of the region. Effective community involvement in health is multifaceted. It requires involvement of the communities in identification of needs and in planning and decision-making processes for health development; an understanding by communities of their responsibility in contributing towards health resources and ensuring proper utilization of the resources available; and acquisition and transmission of better information and knowledge about health and disease in order to take responsibility for maintaining health and preventing illness. It also implies delegation of authority and the allocation of resources to the communities. It calls for the training of health staff able and willing to engage in a dialogue with communities.

39. Countries were requested to provide information on progress being achieved in involving communities in planning and carrying out their national health strategies.
40. Most countries recognize the need for community involvement, which is not new in many countries. Of the 97 countries that provided information on global indicator 2, 78 replied affirmatively, two indicated a partial involvement, and 17 stated that there was no participation.¹ Community involvement appears to be lowest in the countries of the Americas (in 27% of the reporting countries) but is reported to be high in the South-East Asia and the European Regions (100% of the reporting countries). Various mechanisms and approaches have been utilized in some countries for many years to bring about effective community involvement in health and development.

41. The principle of community involvement at all levels of health development has been incorporated in many of the national health policies and in some of the overall development policies. Some countries gave examples of the approaches and mechanisms being used and strengthened, particularly to bring about community involvement in decision-making processes. These include the establishment of national health councils which include community members, and health committees or councils at the local level with the active involvement of community leaders. The role of many nongovernmental organizations, professional groups and voluntary groups (women's groups, youth associations, trade unions, pharmaceutical associations, medical associations, consumers' associations, religious and business groups, the Red Cross or Red Crescent, etc.) in health matters is increasing in many countries and is proving supportive. A few countries have actually decentralized power and authority for the management of health resources to the community level through appropriate administrative reforms. Wherever this has occurred, community participation has been reported to be more effective. In some countries, the control of and contributions to health resources at the community level have increased, for example in the share of hospital beds available at the intermediate level, the financing of health centre construction, and the management of community-based pharmacies. In others, communities are contributing resources such as material and labour for health and volunteer health workers have been trained who are supported by both the health system and the communities. The latter play an important part in the selection of these health workers.

42. Some countries have used and/or extended the role of existing mechanisms for community involvement such as village-level development councils and community councils. Very few have actually introduced appropriate legal and/or administrative reforms to make these mechanisms more effective. In a few countries community involvement has also been organized around specific health problems or projects such as water and basic sanitation, environmental improvements, and immunization campaigns. These have generally been intensive but sporadic involvements and have not been sustained.

43. Several countries have reported that they have not initiated any significant measures for increasing community involvement and have no well-defined policy for this. A few are initiating experimental projects to gain experience.

44. In general, the need to involve communities in health is recognized and accepted by most, if not all, countries, and several approaches are being tried to bring about such involvement at various levels of the health system. The reports give relatively little information on what is effective and what is not, and whether the countries have been able to sustain motivation and involvement. Hardly any information was given on efforts made to promote health literacy through information to the communities about health and disease in order to increase their self-reliance and to inculcate a spirit of responsibility for their own health. The reports do not indicate what difficulties are being experienced in this sensitive and complex area and how some of them are being resolved.

45. The experience of some of the countries appears to indicate that real decentralization of responsibility, authority and resources to the community-level health system is essential. Such experiences need to be shared with other countries so that their relative feasibility in other cultural, political and administrative settings can be examined.

¹ Global indicator 2: The number of countries in which mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning.
46. It is obvious that much more effort needs to be devoted to developing effective education and information strategies to involve individuals, families and communities in taking more responsibility for their health. Countries can learn much from each other through sharing their experience, technologies and materials in this field.

Orientation and training of health workers

47. The health delivery system is labour-intensive in its functions, and health manpower represents its most important asset. The stress on primary health care has placed new emphasis on the need for qualitative and quantitative changes in health manpower, as well as a better geographic distribution of such health manpower. A comprehensive approach to health manpower planning and development efforts based on health systems review and reorientation plans is required. Existing health workers have to be reoriented and trained in order to expand and improve their technical knowledge and skills so that they can function effectively in their new or expanded roles, especially at the community level, and new categories of health workers are needed to complement those that exist in the health systems. Steps to ensure that future health workers receive training that is more appropriate to their expected functions within the health system are also required.

48. Countries were requested to report on progress made in orienting and training health workers to fulfil their role in planning and carrying out the Strategy.

49. The reports indicate that this area in general is receiving much attention in all countries, although to different degrees. Many countries appear to have recognized and accepted the need for reorientation and training of health workers in line with the primary health care strategy and have initiated specific actions to achieve this.

50. The emphasis in a large number of developing countries is on reorientation and training of health workers in the community health services. Many countries have introduced new categories of health workers at the community level and are implementing training programmes for them. Training or reorientation of existing health workers at the community level, such as traditional birth attendants, midwives and community health workers, has been extensively undertaken by many countries. In some, training of volunteers has also been encouraged and supported.

51. The changing roles of nurses and intermediate-level health workers have been recognized by some countries and training programmes have been initiated to prepare them for their expanded roles. Basic training programmes for these health workers are being reviewed and revised to reflect the principles of primary health care and provide community-based orientation in several countries. Countries have not reported on administrative or legal reforms they have undertaken to formalize the expanded or changing functions and roles of these health workers within the health system.

52. Some countries have recognized the need to change the training of physicians and to reorient the existing medical manpower to community health services. In a few countries, community-based medical schools have been initiated, while others are strengthening or establishing faculties of community medicine in medical schools. Some of the developed countries have particularly emphasized the need to give physicians more training in health education and to shift the emphasis in the training of physicians from the hospital-based to the community- and family-oriented physician.

53. The need for training in management and supervisory skills has been recognized in a few countries and workshops/seminars are being developed to improve these skills, particularly for health workers at the middle-management level.

54. Very few countries mentioned the formulation of health manpower development plans consonant with the needs of their health systems. The role of teaching institutions and the needs for the preparation of teachers have not been adequately considered by the countries in their health manpower development efforts.

55. It may be concluded that the principle of improving and strengthening the capacity of health workers, the principal resources in health systems, has been accepted in most countries.
Only a few did not report on any particular initiative in this area. Efforts to date have concentrated much more on the reorientation of existing health workers in community health services or the training and deployment of new categories of health workers at the community level than on the adoption of a more comprehensive approach to manpower development based on a review of health systems and plans for the introduction of the changes required.

56. Development of health systems based on primary health care has important implications for health manpower resources in the health systems. Emphasis on health workers functioning as a health team supporting and complementing each other and on management and supervisory skills increases. Interprofessional conflicts or jealousies can appear if roles are not adequately defined. Countries did not provide information on supporting administrative or legal reforms in this area. Countries also did not provide information on the effect of their training efforts on the actual practice and attitudes of the health workers. Have they become more community-oriented? Are they accepting their role and providing appropriate information so that individuals and communities increase their self-reliance and responsibility in health, or are they still functioning as providers of health care? Has the motivation of health workers improved and been sustained so that they remain in the community-based health services and in rural areas? How are the attitudes of the higher professional-level health workers being modified and interprofessional conflicts being resolved? Adequate attention should also be paid to the development of effective training approaches and methodologies and appropriate learning materials. The role and involvement of training institutions in support of this process is extremely important and effective dialogue with these institutions, as well as with professional groups, has still to be established in order to gain their support for the implementation of health manpower development plans.

57. It is evident that more intensive and simultaneous action is needed in many areas, including changes in basic curricula of health workers; training of well-prepared teachers; reorientation of existing health workers to expand their skills and knowledge in accordance with their new or altered roles; and preparation of new categories of health workers. Essential to this process is the analysis and redefinition of the role of each category of health worker corresponding to each level of the health care system and in relation to each member of the health team.

**Mobilization of material and financial resources**

58. Just as the successful implementation of the Strategy will mean mobilizing all possible human resources, it will also depend on mobilizing all possible financial and material resources. This implies that the existing resources within and among countries will be equitably distributed and more efficiently used. At the same time, additional resources for health will have to be generated. This calls for the countries to review the distribution of their national budgets, in particular allocations to health and health-related sectors, and to reallocate existing resources as necessary for the provision of primary health care, especially to underserved population groups. It further calls for countries to estimate their overall financial needs in order to implement their national strategies up to the year 2000, identify activities for external support, and take appropriate action to generate the necessary support from both national and external sources.

59. Countries were requested to report on progress in the mobilization of material and financial resources.

60. Countries in general experienced difficulties in measuring the percentage of their GNP spent on health and it seems that many countries have not yet developed the mechanisms to estimate the financial resources spent on health. Only 63 of the 122 countries that submitted reports were able to provide an estimated percentage of GNP spent on health and of these more than half spent less than 5% on health.\(^1\) Even fewer (50) were able to provide the percentage of their health budget devoted to local health care.\(^2\) Thus many countries find it difficult to

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\(^1\) Global indicator 3: The number of countries in which at least 5% of the gross national product is spent on health.

\(^2\) Global indicator 4: The number of countries in which a reasonable percentage of the national health expenditure is devoted to local health care.
analyse health expenditure and define precisely what is being spent for primary health care. This is partly due to the existing budget structures or to the lack of simple procedures for budgetary analysis.

61. A few countries have undertaken or initiated reviews of the distribution of their health budget and have indicated the need to increase the allocation of financial resources to primary health care. Reallocation or changes in distribution of existing health budgets has not been found easy, as in general there has been no or very little real increase in health budgets and the expenditure to support the existing health care structure must continue to be met. Without a serious reorientation of health systems, changes in the distribution of the budget will not be feasible in most of the developing countries.

62. Some countries, however, are making efforts to increase the allocation to primary health care either from existing health budgets or by directing any additional resources that become available to primary health care. Several countries have prepared projects in collaboration with bilateral and multilateral agencies to obtain grants or loans to develop the health infrastructure for primary health care, especially in underserved rural and marginal urban areas. In many of the developed countries, concern is expressed about the constant rise of health expenditure, particularly because of the high-cost technologies being utilized. Hence research on health economics, the assessment of existing technologies, and studies on relative cost-benefits and better distribution of resources are receiving special attention. Efforts are also being made to increase contributions from individuals and communities for their health care. Some countries have initiated or expressed interest in developing alternative approaches to financing to increase the efficiency of the health care delivery system and to studies on the cost-effectiveness of different technologies and models to meet the health needs of their people.

63. Very few countries have carried out health resource utilization studies, and even fewer have prepared an overall master plan for resource requirements taking into consideration available national resources and projections for additional resources, national as well as external.

64. The types of health projects being considered for support by some bilateral and multilateral funding agencies indicate that there is a trend towards channelling additional resources to the underserved population and to strengthen some components of primary health care. If this trend continues it may also help to increase allocations from national budgets to support recurring and maintenance costs. Whether this will bring about a more equitable distribution of resources remains to be seen. Most countries need to achieve a real reorientation of their health care delivery systems, giving more emphasis to the provision of health care outside the hospitals, strengthening their activities in prevention and health promotion, and utilizing technologies that are really needed and that they can afford.

65. Managerial processes in the health systems will also require strengthening, particularly the planning process, which should be based on information feedback so that countries can define their priorities more clearly, develop their health budgets according to programmes and not items of expenditure, and analyse and allocate their resources in accordance with their priorities and objectives. More countries will have to identify their overall needs and prepare a plan for the mobilization of resources, both national and external.

Coordination within the health sector, and with other sectors concerned with health development

66. The strategies for health for all call for increased coordination within the health sector, especially collaboration between the various health services institutions and agencies belonging to government, social security and the private sector, and coordination and effective linkages between the various levels of health care systems. As health is recognized as an integral part of the development process, the adoption of intersectoral development strategies is not only essential for the achievement of health for all but equally necessary for progressive advances in all other sectors and towards social equity. Countries are urged to devise mechanisms and ways for ensuring adequate and effective cooperation between health and other sectors.
67. The review of progress has shown that efforts are being made to varying degrees in these areas. In general, in many countries there appears to be an increased consciousness and awareness of the need to bring about more effective coordination within and outside the health sector, and efforts to improve coordination have been initiated. Coordination appears to be relatively easier to achieve in smaller countries.

68. Several approaches have been undertaken by countries, such as the establishment of more appropriate organizational structures for the health system, including definition of functions and relationships of different levels of the health care delivery system; improvement of linkages and referral mechanisms between the community-based health services and hospitals; and establishment of national health development councils on which a number of institutions, including the private sector, are represented. Some countries are unifying their national health system, incorporating the social security institutions in the structure for delivery of health services where such participation is already extensive or increasing in order to achieve better coordination and avoid duplication of services. The degree to which effective coordination has developed, especially between the different levels of the health care system and among the special health programmes, has not been reported adequately.

69. Many countries are instituting mechanisms for intersectoral action on health, for example, the establishment of intersectoral committees to promote health at the ministerial level or to deal with specific health action programmes in such fields as environmental health, nutrition, population, and rural development. At the intermediate and local levels, village development committees and village health councils or committees which include representatives of various sectors as well as community leaders have been set up. A few countries have established national health development networks, but their effectiveness has not been reported. From the reports it appears that efforts to achieve intersectoral coordination at intermediate and village levels have been more effective where administrative or legal measures have been taken to increase authority for action at those levels.

70. The reports also indicate that there is an increased awareness and recognition of the need to incorporate health components in development projects, especially agricultural and industrial development sectors. Health implications of rapid urbanization and industrial development are being increasingly recognized and some countries have taken measures such as zoning for industrial projects; measures to limit urban migration; and monitoring of people's health where large-scale development projects or construction of irrigation and hydroelectric systems have been undertaken. Projects which may have deleterious effects on health are being monitored more carefully and safety rules are being introduced in industrial projects in the developed countries.

71. Not all countries have reported progress in achieving intersectoral coordination. Some have found it very difficult to involve other sectors in health development or to include a health component in development projects being undertaken in areas where health services are inadequate or nonexistent.

72. While a variety of mechanisms have been introduced and institutionalized by many countries, their degree of effectiveness is not known. Where coordination appears to have been achieved to some degree within the health sector, real decentralization of authority and power has been introduced through administrative and legal measures. Coordination among different levels of the health care delivery system and institutions and between different categories of health workers through better definition of their roles and tasks still needs much attention.

73. Countries are giving increasing attention to health hazards and impacts of development projects, but not enough to introduce the health component when such projects are being developed for hitherto underserved areas. The health sector will have to engage other sectors selectively in a process of joint planning for health. In the prevailing economic conditions in most countries, the ability of the health sector to ensure an adequate allocation of resources for primary health care is limited and the situation demands a more active dialogue and involvement with the often more powerful and affluent sectors of the national economy. Likewise, efforts to mobilize support from the private sector and the nongovernmental organizations will need to be intensified.
Cooperation with other countries

74. The Strategy for Health for All underscores the need for intercountry cooperation, as some developing countries - and particularly the least developed ones - will not, in the present state of their health resources and economic development, be able to achieve their health objectives alone. Cooperation among countries in sharing resources and the transfer of technical and economic resources from the developed to the developing countries are therefore crucial.

75. Countries were requested to provide information on the cooperation developed with other countries in implementing their national strategies and the amount and types of resources received or offered for health development.

76. All countries that reported expressed the need for more effective cooperation among countries, particularly in the areas of training, research, information exchange and communicable disease control. Some referred to the need to increase the flow of technical and economic resources from the developed to the poorer countries. Specific information on the actual amount and trend of resource flow from the developed to the developing countries is lacking.

77. Existing mechanisms for regional or geopolitical cooperation have been utilized and in some cases strengthened for cooperation in health matters as well as promotion of specific cooperative efforts. Examples given of these mechanisms are the Association of South-East Asian Nations (ASEAN) and the South Pacific Commission in the Western Pacific Region; the Council of Arab Ministers of Health and the Council of Ministers of Health of the Arab Countries of the Gulf Area in the Eastern Mediterranean Region; the Nordic Council, the Council for Mutual Economic Assistance, the Organization for Economic Cooperation and Development and the Council of Europe in the European Region; South Asian Regional Cooperation and ASEAN in the South-East Asia Region; the River Plate Basin Group, the Caribbean Community, the subregional Andean Group of countries, and the Meeting of Ministers of Health of Central America and Panama in the Region of the Americas; and the United Nations Economic Commission for Africa in the African Region. In many regions or subregions, these mechanisms are being used to attempt to increase the flow of financial resources from the developed or richer countries to the developing and less fortunate countries, for example in the Eastern Mediterranean and European Regions. The agreement between the Nordic countries has been amended in the spirit of health for all to emphasize preventive health activities and primary health care.

78. In the African Region, technical cooperation among developing countries is playing an increasing part, especially with regard to the manufacture and distribution of essential drugs and vaccines. Lesotho has set up a pharmaceutical manufacturing plant which is supplying Botswana, Malawi, Mozambique, Zambia and other countries with drugs under nonproprietary names. Zimbabwe is similarly involved through the Central African Pharmaceutical Services (CAPS). The Great Lakes Economic Community has brought together Burundi, Rwanda and Zaire for the production and control of essential drugs and vaccines. Laboratories in Ethiopia, Ghana, Kenya, Madagascar, Senegal and Zimbabwe are acting as collaborating centres for vaccine quality control. Training courses using TCDC mechanisms have been organized in Kenya to enable participating countries to share their experience of essential drug distribution in rural areas.

79. Special meetings of ministers of health have been organized in South-East Asia, Africa and the Americas to promote and foster intercountry consensus and cooperation on important health matters among the countries of the region and to promote concerted action for the implementation of strategies for health for all. Regional health charters have been formulated in the South-East Asia, African and Eastern Mediterranean Regions, and regional targets have been established by the countries of the Americas and are being considered by the European Region.

80. Intercountry cooperation in health is a long-established tradition, especially in the surveillance and control of communicable diseases and training. This cooperation is now being extended for the promotion of efforts which, it is hoped, will stimulate national health development based on primary health care and promote effective action on priority health
problems affecting a large majority of people in the developing countries. Sharing of technical know-how and information is essential for this process and more effective mechanisms must be developed for information flow. Real equity, however, can only be achieved through the transfer of financial resources from the richer countries to the poorer, especially the least developed countries which lack the resources to become self-reliant or even to improve their existing health services. Monitoring of these resources is important to reflect trends as well as to ensure that they are being channelled to priority health problems and to extend primary health care to the hitherto unserved and underprivileged population groups. The emphasis must however be on building up national capacities so that the countries ultimately become self-reliant.

III. REGIONAL AND GLOBAL ACTION IN SUPPORT OF IMPLEMENTATION OF THE STRATEGIES

81. The Global Strategy identifies international action to be taken by WHO to support national action for the implementation of strategies for health for all. It specifically calls for the formulation of the Organization's General Programmes of Work in response to the Strategy, and in relation to the restructuring of the Organization in the light of its functions in support of the Strategy, as decided by the Thirty-third World Health Assembly (resolution WHA33.17). The Organization is requested to promote and coordinate action in support of the Strategy within the United Nations system, to mobilize the support of banks, funds and multilateral and bilateral agencies for health, and to promote the Strategy through nongovernmental organizations and the use of mass media.

82. WHO is also requested to facilitate technical cooperation among its Member States, and to promote intersectoral action at international level through the establishment of bilateral and multilateral arrangements with other organizations of the United Nations system. Other areas identified for WHO's action are international mobilization of people and groups who can support the Strategy and coordination of the international transfer of resources in support of the strategies of developing countries.

83. This section contains a review of WHO's regional and global health policies and programme directions and its functions and structure, with particular emphasis on their relevance to the support of national strategies. Action taken by the governing bodies of WHO and its Secretariat in support of the Global Strategy as defined in the Plan of Action is also examined.

Regional and global health policies, strategies and programme directions

Relevance

84. The process of formulation, updating and adoption of regional and global strategies has been a very dynamic one and was launched following the Declaration of Alma-Ata and the adoption of resolution WHA32.30 by the Thirty-second World Health Assembly in 1979. In all regions, regional strategies were formulated during 1980 and reviewed during 1981 in the light of the Global Strategy for Health for All. The process for the formulation of regional strategies, policies and plans of action has varied a little from region to region.

85. The overall objective of the regional strategy for health for all by the year 2000 for the African Region1 is to provide primary health care to all individuals, families and communities in the Region with their full participation and to strengthen regional solidarity through TCDC. The specific objectives focus on the development of comprehensive health systems based on primary health care, promotion and utilization of appropriate health technologies for the eight essential elements of primary health care, and promotion and support activities. The strategy identifies major political, economic and technical measures to be taken for the achievement of objectives.

1 Regional strategy to achieve the social target of health for all by the year 2000 (document AFR/RC30/3).
86. The regional strategies of the Region of the Americas,⁴ as adopted by the Regional Committee in October 1980, serve as a broad guide for the countries of the Americas to attain health for all by the year 2000. The goal of health for all is defined in terms of priorities for human groups, health status and structure, and wellbeing profiles. The principal strategy adopted to achieve those goals is that of primary health care. The strategy includes regional objectives and minimum regional goals, which reflect the reality within the Region. A plan of action for the implementation of regional strategies for health for all by the year 2000² has also been adopted, reaffirming the regional objectives and goals.

87. The health policies in the South-East Asia Region, as reflected in the Charter for Health and the resolutions of the Regional Committee, are also directed towards the attainment of the social goal of health for all by the year 2000. Their aim is to promote harmonious and integrated health development in all countries of the Region so as to reduce the inter- and intra-country disparities in the health field. The regional strategy has also been refined and updated in the light of the Global Strategy, incorporating its main targets; its principal objectives relate to the improvement of health status, health care delivery, and quality of life.

88. The regional strategy in the European Region aims at a fundamental reorientation of health policies in three main areas; promotion of life-styles conducive to health; reduction of preventable conditions; and provision of adequate, accessible and acceptable health care, based on the development of primary health care. Regional targets are also being considered, and these together with a revised regional plan of action will be submitted to the thirty-fourth session of the Regional Committee in 1984.

89. The main long-term objectives of the strategy for the Eastern Mediterranean Region are to achieve general coverage of the population by primary health care and to increase life expectancy to a minimum of 65 years. The strategy includes specific objectives relating to the eight essential elements of primary health care and identifies the principal support measures - political, economic and technical. It emphasizes generation and mobilization of resources and intercountry collaboration.

90. In the Western Pacific Region, a regional strategy and a plan of action for the implementation of the regional strategy have been adopted by the Regional Committee. The main thrust of the regional strategy is the development of health systems based on primary health care, with particular emphasis on the improvement of managerial processes, reorientation and training of health and health-related personnel, research on appropriate technologies and health care delivery systems, practical evaluation procedures, development of information systems, exchange of information, and mobilization of external resources.

91. At the global level, following the adoption of the Global Strategy (resolution WHA34.36), a plan of action for implementing the Strategy was approved by the Thirty-fifth World Health Assembly, which called on the Member States, regional committees and the Director-General to carry out specific activities in support of the Strategy (resolution WHA35.23). The Global Strategy is built on the concept of countrywide health systems based on primary health care. The main thrust is the development of the health infrastructure, starting with primary health care, for the delivery of countrywide programmes that reach the whole population and that utilize appropriate technologies. Crucial to the Strategy is a high degree of community involvement and coordination within the health sector and between health and other sectors.

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³ Documents SEA/HSD/43 Rev.1 and SEA/RC35/7.
⁵ Documents EM/RC30/9 and EM/RC30(B1)/7.
⁷ Plan of Action for Implementing the Global Strategy for Health for All, op. cit.
92. In conclusion, it can be stated that all regions have been engaged in dynamic processes aimed at the formulation and adoption of appropriate regional policies and strategies for the attainment of the goal of health for all. In three regions, regional health charters have been formulated. One region has adopted specific minimum regional goals and another is engaged in developing specific regional targets. These regional strategies conform to the principles of the Alma-Ata Declaration, are highly relevant to the attainment of health for all, and are supportive to the implementation of national strategies for health for all. All regions have also initiated planning processes for the implementation of their strategies, the progress of which is being reviewed periodically. The overall process has linked the Member States, the Secretariat and the governing bodies of the Organization as a whole and provides for a continuing interface in the implementation, monitoring, refining and evaluation of the strategies at all levels.

Programme directions

93. The Sixth General Programme of Work for the period 1978-1983 was implemented during a transitional period marked by great policy changes in the light of resolution WHA30.43, which defined the goal of health for all by the year 2000, and resolution WHA34.36, by which the Global Strategy for Health for All by the Year 2000 was adopted. The Programme was thus reviewed at all levels and to some extent modified for the periods 1980-1981 and 1982-1983 to give greater emphasis to areas which supported the building up of national and WHO capacities for the development and implementation of their strategies for health for all.

94. In the light of these policy developments, the Executive Board at its sixty-fifth session, in January 1980, decided that the focus of the proposed Seventh General Programme of Work should be on the long-term goal of health for all and on WHO's response to the Global Strategy for attaining that goal.

95. The Seventh General Programme of Work,¹ which was approved by the Thirty-fifth World Health Assembly in resolution WHA35.25, is the first of the three general programmes of work of WHO needed to cover the period until the target date of the year 2000. The targets for the Seventh General Programme of Work are therefore intermediate targets for the period 1984-1989 in relation to the long-term targets for the year 2000. The Programme constitutes WHO’s support to the national and regional strategies for attaining health for all by the year 2000, and to the Global Strategy that is the synthesis of these national and regional strategies.

96. The Programme was prepared following extensive consultations at national and regional levels of the Organization and hence represents the Organization's response to the individual and collective needs of its Member States in connection with the implementation of the strategies for health for all. The principal objective is to promote, coordinate and support the efforts of Member States individually and collectively in implementing the Global Strategy. The Programme consists of priority issues for WHO action in the health sector and in other sectors concerned and is aimed at supporting the development of comprehensive health systems, based on primary health care, for the delivery of health programmes that make use of appropriate health technology and that have a high degree of community involvement. The Programme includes objectives and targets in support of the development of health system infrastructure and health science and technology and identifies broad approaches for WHO’s action in specific component areas.

97. The main principles guiding the programme budget for 1982-1983² were the application of interlinked efforts to give effect to the Strategy for Health for All through the individual and collective action of the Member States; to provide valid information to this end; to improve the capacity of Member States to absorb and apply this information in the light of their specific circumstances; and to mobilize national and international resources in support of the endeavours of developing countries in these fields.


98. The extent to which the above principles were being put into practice was reviewed and a number of important lessons were learned which were applied to the preparation of the programme budget for 1984-1985,1 which has the following general objectives:

- to build up national capacities to work out and carry out a national strategy for health for all by the year 2000 and to strengthen the health infrastructure to this end;
- to strengthen national capacities to identify and absorb scientific, technical, social and behavioural knowledge that is relevant to the country's health and socioeconomic situation, and to develop appropriate technology for the national strategy on the basis of this knowledge;
- to promote research aimed at developing new knowledge and new tools required for the Strategy for Health for All;
- to ensure the most effective and efficient use of all available resources throughout the world for the Strategy for Health for All - national, multinational, international, nongovernmental and voluntary.

99. It may be concluded that the programme directions of the Organization are highly relevant to the implementation of national, regional and global strategies. The active participation of the Member States at the national, regional and global levels has been crucial to achieving this. The attainment of the objectives set forth will be determined to a large extent by the way the Member governments use WHO's resources and also by the monitoring and evaluation processes applied for the implementation of national, regional and global strategies.

Relevance of WHO's functions and structures in relation to implementation of the Strategy

100. The Global Strategy for Health for All called for continued restructuring of the Organization at national, regional and global levels to permit the regional committees, the Executive Board, the World Health Assembly and the Secretariat to carry out the responsibilities devolving on them in accordance with resolution WHA33.17 on the study of WHO's structures in the light of its functions.

101. The recommendations contained in the Director-General's report on the study2 stressed the need to correlate better the work of the Organization at various levels; to strengthen the mechanisms for continuing dialogue between each Member State and the Organization; and to intensify the work of the regional committees, especially in their monitoring and control functions with respect to the implementation of the regional policies and strategies for health for all. The recommendations also included the strengthening of the role of the Executive Board and the Health Assembly in the work of WHO and improvement of the correlation of the work of the governing bodies of the Organization.

102. A review of the regional reports on monitoring of progress in the implementation of health-for-all strategies indicates that significant efforts have been made towards the implementation of the Health Assembly's decisions contained in resolution WHA33.17. The managerial processes for WHO's programme development have been streamlined and strengthened, with emphasis on improving the coordination and management of WHO's work at country, regional and global levels.

103. The regions have adopted various mechanisms to implement the recommendations. Organizational studies or reviews of existing structures have been carried out in all the regions. Changes have been introduced aimed at realignment of responsibilities, improvement of coordination, promotion of the multidisciplinary approach in programme development, and improvement of monitoring of WHO's collaborative activities. Measures to strengthen the role of the WHO programme coordinator and representative (WPC) at country level through greater delegation of authority and responsibility have been introduced in order to improve the management and monitoring of WHO's activities at this level, and the regions have initiated joint reviews of the policies and programmes with some Member countries through the visits of multidisciplinary teams.

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2 Documents WHA33/1980/REC/1, Annex 3, and EB65/1980/RCC/1, Annexes 8-10.
104. Participation of the Member States in the review of intercountry programmes is being intensified in all regions through the establishment of coordinating/consultative committees which include senior representatives from health and other relevant sectors. Mechanisms for coordination of research, mobilization and generation of financial resources, and cooperation among countries in health matters are also being strengthened. The use of national expertise and national and regional institutions in collaborative activities has also increased.

105. At the global level several mechanisms have been strengthened or introduced to improve coordination and participation of different levels of the Organization and its governing bodies in programme development evaluation. Particular attention is being given to the coordination of activities in support of the implementation of national strategies and to improve linkages between the programmes dealing with the building up of the health system infrastructure and those dealing with health science and technology, as well as their effective monitoring and evaluation. Procedures have been adopted to improve the correlation of the work of the regional committees, the Executive Board and the Health Assembly. A number of working groups and committees set up by the Board have facilitated active discussions and in-depth reviews of various programme matters. The Assembly has also begun to give more attention to the implementation of its main resolutions related to the health-for-all strategies by the Member States, the regional committees, the Executive Board and the Secretariat.

106. The Organization has continued to strengthen coordination with other organizations of the United Nations system, especially UNICEF, UNFPA and UNDP, for support to the health-for-all strategies. Coordinating mechanisms with several bilateral agencies and nongovernmental organizations to obtain support for the implementation of national strategies are also being developed.

107. A number of measures have been implemented to ensure that WHO's support to the implementation, monitoring and evaluation of strategies for health for all at all levels is coordinated and meaningful, although much still remains to be done. The main objective of the changes introduced in the structures and mechanisms is to provide maximum and meaningful support to the Member States in the implementation of their national strategies. The essential ingredient in this process is the active participation of Member States in guiding, coordinating, monitoring and evaluating WHO's collaborative activities at all levels. The Member States will also have to improve further the coordinating mechanisms within their own countries so that they are able to ensure the mutual relevance and support of their own health development strategy and of their technical cooperation with WHO and with other Member States of WHO.

Support provided by WHO's governing bodies

108. The regional committees, the Executive Board and the Health Assembly have provided important support for the formulation of regional and global strategies and the plan of action and in the follow-up of their implementation since the adoption of the goal of health for all by the Thirtieth World Health Assembly in 1977 and the launching of the Global Strategy in 1979.

109. Regional strategies for health for all have been adopted by all regional committees (except in the Eastern Mediterranean Region, where the Regional Committee did not meet between 1979 and 1983). Plans of action for the implementation of regional strategies have been approved by the regional committees in the African, American and Western Pacific Regions. Charters for health development have been formulated in the African, the South-East Asia and the Eastern Mediterranean Regions. The Regional Committee for Europe has also reviewed draft regional targets. Regional contributions to the Seventh General Programme of Work (1984-1989) were considered and approved by the regional committees, which subsequently also reviewed and approved the 1984-1985 programme budget proposals to give effect to the implementation of WHO's collaborative action in support of national and regional strategies.

110. Some of the regional committees have also carried out special activities in support of regional strategies. The Regional Committee for Africa considered and approved special programmes of cooperation with Angola and Chad, in the light of local situations in those countries. Concerning apartheid, the Regional Committee adopted the Brazzaville Declaration following an International Conference on Apartheid and Health in 1981 and considered appropriate measures to implement the plan of action formulated at the Conference. The Regional Committee
for the Americas adopted a five-year plan for women in health and development which was integrated into the regional plan of action. It also promoted increased cooperation between the health and agricultural sectors through a series of resolutions it adopted on the programme for animal health.

111. The regional committees have also provided support in the monitoring of the strategies, reviewed the first progress reports on the implementation of national strategies, and approved resolutions urging Member States to strengthen their national mechanisms for the monitoring and evaluation of their strategies.

112. At the global level the action taken by the Executive Board and Health Assembly in support of the strategies is coordinated and linked with that taken at regional level. The Executive Board at its sixty-ninth session, in 1982, finalized the Plan of Action for the implementation of the Strategy, prepared the Seventh General Programme of Work, and considered the global targets. It also reviewed the report on the international flow of resources and financial needs of the Strategy.\(^1\) The Thirty-fifth World Health Assembly reviewed and approved the Plan of Action for implementing the Strategy and the Board's recommendations concerning global targets. In resolution WHA35.25, the Assembly also approved the Seventh General Programme of Work covering the period 1984-1989. In reviewing the international flow of resources for the Strategy, it called for sustained support from the more affluent countries with well-defined strategies for health for all. In 1983 the Board at its seventy-first session and the Thirty-sixth World Health Assembly reviewed and approved the programme budget proposals for 1984-1985 and reviewed the Director-General's report on the implementation of the Strategy in accordance with resolution WHA34.36.

113. The governing bodies of WHO will need to continue this leadership role in the monitoring and evaluation of the Strategy and in promoting the necessary action at national, regional and global level to support Member States' efforts to achieve the goal of health for all. Crucial to this endeavour are the mobilization of internal and external resources for health and cooperation among countries.

Support provided by the WHO Secretariat

114. All the work of the Organization is being increasingly geared to support Member States in their endeavours to prepare and implement their strategies for health for all. This is a gradual process; as implementation proceeds, the areas requiring major support become more clearly identified and hence will receive even greater thrust in the programmes of WHO. As mentioned in paragraph 93, the Organization's programme at all levels was reviewed and to some extent modified for the periods 1980-1981 and 1982-1983 to give greater emphasis to areas which supported the building up of national and WHO capacities for the development and implementation of their strategies for health for all. The reports of the Director-General on the work of WHO for 1980-1981\(^2\) and 1982-1983\(^3\) describe in detail the activities of the Organization in different programme areas in support of the Strategy for Health for All at all levels.

115. The Plan of Action includes a number of specific actions to be taken by the Secretariat in support of the formulation, implementation, monitoring and evaluation of the Global Strategy. Among the major areas for such actions are promotion and information dissemination; development and monitoring of national strategies; support to national action for developing health systems, including strengthening of the managerial processes; promotion and coordination of technology and research in support of the implementation of national strategies; mobilization of external resources for health; and promotion of intercountry cooperation and of intersectoral action at international level. Actions in these directions have been taken at different levels of the Secretariat.

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1 Document EB69/1982/REC/1, Annex 1.
ANNEX 3

Promotion and information dissemination

116. The Global Strategy, once approved by the World Health Assembly, was widely disseminated to the Member States, other United Nations, intergovernmental and nongovernmental organizations, and many other institutions. A number of publications supporting the Strategy to guide and support the development of national strategies have been prepared and widely disseminated to Member States, education and training institutions, individuals and agencies to enlist their support for the strategies.

117. The Global Strategy has been promoted through contacts with governments, national and regional institutions, intergovernmental and nongovernmental organizations, and health professional groups at national and international levels. World Health Day 1983 was dedicated to the goal of health for all, with the theme "Health for all by the year 2000: the countdown has begun".

118. At the regional level, numerous activities have been undertaken to promote the Strategy for Health for All and relevant technical information has been widely distributed to Member countries. In the Region of the Americas, 250 senior national personnel from top policy and administrative levels in the health and other sectors and staff of the Organization were given orientation in regional seminars in order to promote understanding of the implications of national and regional strategies for health for all. The Regional Office for South-East Asia organized a special meeting of ministers of health of the Region to promote the strategies and to identify priority areas for action. All regions are giving increasing attention to the coordination of production and dissemination of technical information on health. The European Region is giving emphasis to the production of new types of publications relating to critical programmes, such as the protection and promotion of the health of specific population groups. It is also promoting the formulation of programmes and plans of action in innovative areas of the regional strategy, especially inducing healthy behaviour and motivating individuals to reduce self-imposed risks.

Development of national strategies for health for all

119. Very few countries have requested intensive support from WHO for the formulation of their national strategies. Support has been requested for specific components of the national strategies such as formulation of national health plans, preparation of monitoring reports, activities for the reorientation of health manpower, and the preparation of projects for external support.

120. The UNICEF/WHO Joint Committee on Health Policy, in the light of the strategies, has agreed to provide systematic and joint support to countries with a clear and continuing national commitment to implement the primary health care approach. The process of identifying countries, securing official commitments, and initiating the development of the national strategies has been rather slow. Joint UNICEF/WHO consultation missions have visited a few countries to identify lines of action to be taken to support the primary health care approach.

121. To support the implementation of national strategies, WHO has collaborated with countries in the development of important areas such as organization and reorientation of health systems based on primary health care, including the strengthening of the managerial processes; orientation and training of health personnel; promotion of community involvement; and intersectoral action in health.

122. Guiding principles for strengthening the managerial processes in national health systems have been prepared and provided to the countries to support action for the translation of national strategies and policies into well-defined health plans and programmes. Technical cooperation has been provided upon request to countries for the formulation of national health plans, strengthening of the planning structures and processes, estimation of resource requirements, and definition of priority areas for external cooperation. Intercountry and national training activities in health management and health planning are being supported in

1 World Health Organization, "Health for All" Series, Nos. 1-7.
most of the regions. The Organization has also undertaken several collaborative activities at the global level in support of the reorientation of health systems and strengthening of the managerial processes in health systems. Two publications - "National health systems and their reorientation towards health for all: guidance for policy-making" (National health systems and their reorientation towards health for all: guidance for policy-making. Geneva, World Health Organization, 1984 (Public Health Papers, No. 77). and "Health system support for primary health care" (Health system support for primary health care. Geneva, World Health Organization, 1984 (Public Health Papers, No. 80).)

1 A number of collaborative activities have been supported in the area of orientation and training of health workers. The emphasis of these activities has been on support to national and regional institutions for education and training of health workers; promotion and support to the development of learning materials, especially for primary health care workers; development and implementation of continuing education programmes; and review and reorientation of curricula. Technical Discussions on "The role of universities in the strategies for health for all" will be held at the Thirty-seventh World Health Assembly in 1984. On request, countries have also received support in the health manpower planning process.

125. To support the development of intersectoral action in health, WHO is reviewing concepts and experiences related to the contribution of other sectors to health. A fact-finding inquiry on the contribution of other sectors to health was followed by a consultation (India, 1982) organized to identify the crucial social and economic development factors which influence health; to understand the role of intersectoral collaborative action for the involvement of health; to support mechanisms and appropriate strategies to promote, plan and implement intersectoral actions at various levels; and to identify needs for action-oriented research. In order to strengthen the health component of integrated rural development projects, assessments of this component have been carried out in a number of countries (Bangladesh, Nepal, Sri Lanka) in collaboration with FAO and the Centre for Integrated Rural Development for Asia and the Pacific. Similar activities are now being undertaken by the Regional Office for Africa and the Centre for Integrated Rural Development for Africa.

126. The Secretariat has continued its many collaborative activities in countries in support of the strengthening and development of the priority components of primary health care. Approaches for integrated delivery of these programmes through health systems based on primary health care are still to be developed. Guiding principles are needed to assist countries in the organization and delivery of priority health components in an integrated manner at all levels of the health care delivery system. Educational activities to support further the involvement of individuals, families and communities in their own care and in preventing health problems and reducing self-imposed risks need stronger emphasis in the Secretariat's work.

Research and technology development

127. Among the areas identified for WHO support for the implementation of the Global Strategy for Health for All are: the international coordination of research to identify and generate appropriate health technology for the essential elements of primary health care; promotion and


3 Community involvement in health systems for primary health care (document SHS/83.6).
development of health systems research, including support to such research in countries; strengthening of national research institutions; promotion of intercountry collaboration; and research and development on specific issues of major concern on health.

128. Many countries, especially in the developing world, have not developed an effective national organization for the management of health research or even for articulating health research policy. At the national and international levels growing concern has been expressed over the disparities between developed and developing countries in research and development investment and the lack of coordinated global research efforts that are relevant to worldwide health problems. WHO's efforts at the regional and global levels are being directed at improving the coordination of research efforts and identification of priority research needs for health systems based on primary health care. At the regional level, the mechanisms for coordination of research have been reviewed and are being further strengthened through the regional advisory committees on medical research. Among the areas receiving greater emphasis are: the identification of national and regional institutions to develop regional networks for undertaking operational research on relevant issues; promotion and formulation of national health policies on research; and establishment of more effective linkages between the research institutions and the ministries of health. At the global level, the global Advisory Committee on Medical Research and the Organization's special research programmes (the Special Programme for Research and Training in Tropical Diseases, the Special Programme of Research, Development and Research Training in Human Reproduction, and the Diarrhoeal Diseases Control Programme) are being challenged to give greater consideration to operational research and health systems research issues and to support the development of this type of research.

129. Information on appropriate technologies in primary health care is being compiled and disseminated by the regional offices and at the global level. Emphasis is being given to the review and development of appropriate and relevant diagnostic technologies for primary health care. Support has also been provided for the development of appropriate rehabilitative technology for the community level and adaptation of technical aids for the disabled. Links are being established with the universities and nongovernmental organizations in the development and improvement of technologies, with particular reference to the primary care level. The European Region is emphasizing the assessment and relevance of high-cost technologies used in the Region with a view to reorienting and rationalizing the use of technology in health care. This effort will be useful for developing countries that are concerned with the introduction of such technologies in their health care systems.

Mobilization of external resources for health

130. Several actions related to the mobilization of financial resources at the international level are proposed in the Global Strategy. Among these are an estimation of the order of magnitude of financial and material needs for the Strategy, promotion of resource transfers from developed countries to developing countries that are ready to devote substantial additional resources to health, and review of the nature and size of such transfers with the aim of satisfying the needs of the Strategy. The Strategy further calls for the strengthening of the capacities of developing countries to prepare proposals for possible funding by their governments and from external resources. The establishment of regional and global mechanisms to identify needs and facilitate the rational transfer of resources for health are also crucial for the coordination of resource mobilization.

131. In May 1981, the Thirty-fourth World Health Assembly adopted resolution WHA34.37 on "Resources for strategies for health for all by the year 2000", in which it urged Member States that are in a position to do so, and the relevant agencies, programmes and funds of the United Nations system, as well as other bodies concerned, to provide financial and other support to developing countries for the implementation of national strategies to achieve health for all by the year 2000. It also requested the Director-General to take appropriate measures for identifying external resource requirements in support of well-defined strategies for health for all and to support developing countries as required in preparing proposals for external funding for health.

132. A review of the health expenditures, financial needs of the Strategy for Health for All and the international flow of resources for the Strategy was made in 1981.\footnote{See document EB69/1982/REC/1, Annex 1.} Notwithstanding
the many difficulties in arriving at these estimates, the review indicated a large gap between what is available now (US$ 2 to US$ 3 per head) and what seems necessary to fulfill the aspirations of all countries of the world in line with the resolutions on health for all. This applies especially to the poorer developing countries where the needs are greatest. The review also provided estimates for the required resource transfer from the developed to the developing countries.

133. A Health Resources Group for Primary Health Care (HRG) was established by the Director-General in 1981 with the aim of promoting the rationalization of the international flow of resources for the Strategy and increasing the flow if necessary. It was also recognized that the main operational action for implementing the Strategy for Health for All must take place at country level, with the support, as necessary, of other Member States, other partners in health work, and WHO at regional and global levels. Countries were invited to carry out "country resource utilization reviews" as a possible approach to initiate action and attract external collaboration in health. After such reviews were tried out in a few countries in 1980-1981 (Benin, Ecuador, Gambia, Sri Lanka and Sudan), general guidelines were evolved which were subsequently utilized in other countries.

134. A "country resource utilization review" (CRU) is a study carried out by a developing country, involving the ministry of health, the planning authorities and departments in other sectors, to analyse resource flows and to identify total requirements, resources available or committed, and opportunities for reallocation of internal resources and mobilization of external resources in relation to health for all in general and primary health care in particular. To date CRUs have been carried out in Gambia (1980), Sri Lanka, Benin, Ecuador and Sudan (1981), Nepal and Malawi (1982), and Bangladesh, Papua New Guinea, Democratic Yemen, Yemen and Bhutan (1983). CRUs in Guinea-Bissau and Lesotho were planned before the end of 1983 and in 10 other countries in 1984. CRUs have generally been financed by external funds (bilateral agencies): they include proposals or "ideas" for external resource requirements and can be used by the countries in negotiations for resources for health from both national and external sources. The real value is thus dependent on the use the countries make of them, especially to attract funds where they are most needed. Benin and Gambia, for example, used their CRU documents for their health sector presentations to a round-table meeting with interested funding agencies and have attracted some support.

135. The regional offices have continued to provide support to countries in the development of specific project proposals for external cooperation in priority areas of primary health care such as maternal and child health and family planning; diarrhoeal disease control; expanded programme of immunization; water and sanitation; and improvement of the physical infrastructure for primary health care. Financial support for these projects has been provided by UNFPA, the World Bank, the Inter-American Development Bank, the Arab Fund for Economic and Social Development, and bilateral donors.

136. In spite of the increasingly unfavourable world economic situation, the existing level of resource flow from the many bilateral and multilateral agencies was maintained during 1981 and 1982 for the support of health programmes and projects aimed at achieving the goal of health for all by the year 2000. Australia, Denmark, the Federal Republic of Germany, Italy, Japan, the Netherlands, Norway, Saudi Arabia, Sweden, the United Kingdom of Great Britain and Northern Ireland and the United States of America have been among the largest contributors, together with UNFPA, UNICEF, UNDP, the Arab Gulf Programme for United Nations Development Organizations (AGFUND), and the Japan Shipbuilding Industry Foundation.

137. While in general the Organization's efforts for the mobilization of external resources in support of the Strategy for Health for All have been intensified, much more remains to be done in the rationalization and more efficient use of national resources for health. An increased flow of external resources for health implies an even greater financial commitment by the countries to absorb the recurrent costs generated by additional investments in health infrastructure and to continue the level of operations when the external funding declines or is terminated. Without a serious effort at the national level to allocate resources to primary health care, consider alternative ways of financing the health system, promote increased collaboration of other sectors for health, especially through incorporation of the health component into development projects, and strengthen the management of health systems to improve efficiency and effectiveness, it will be very difficult for the countries to achieve any degree of self-reliance.
Promotion of intercountry and international cooperation in health

138. Intercountry cooperation and coordination with other organizations of the United Nations system and with intergovernmental and nongovernmental organizations have been promoted and fostered extensively in the development and implementation of the Strategy. Such efforts have been made at the country, regional and global levels and the levels and types of cooperation reported by the countries are described earlier in this report.

139. At the regional level, cooperation with the regional economic commissions of the United Nations, regional economic cooperation agencies, and geopolitical groups has been promoted in support of the regional strategies. With the Economic Commission for Africa, a five-year plan is being developed on priority areas for collaboration, which include essential drugs, nutrition, promotion of the role of women in development, drinking-water supply and sanitation, and management training. In the Americas, areas for collaborative action are being defined with the Economic Commission for Latin America, the Inter-American Development Bank and the regional offices of UNICEF. In the South-East Asia Region, support for the Strategy is being promoted through ASEAN and other groups, one of which has established a study group on health and population activities. Close links with the Economic Commission for Europe on environmental matters, traffic accidents, and statistics already exist and contacts with several geopolitical groups for promotion of intercountry collaboration are being strengthened. The Economic and Social Commission for Asia and the Pacific, along with UNICEF and WHO, sponsored an intergovernmental meeting on health and development in the Western Pacific Region.

140. At the global level contacts with the organizations of the United Nations system, the geopolitical groupings of countries that transcend regional boundaries, and the nongovernmental organizations have been strengthened and promoted. Coordination within the United Nations system continued to be an important concern, particularly in view of resolution 34/58 adopted by the United Nations General Assembly in 1979 entitled "Health as an integral part of development".1

141. The Director-General presented the Global Strategy to the Economic and Social Council in 1981, and a progress report on the implementation of General Assembly resolution 34/58 to the Council in 1981 and to the General Assembly in 1982. A further progress report will be presented to the Council in 1984.

142. WHO has maintained its full participation in the work of the Administrative Committee on Coordination (ACC) and its subsidiary bodies. It was agreed in the Consultative Committee on Substantive Questions (Programme Matters) to identify a few areas for joint planning. A baseline survey of the existing activities of other organizations in support of primary health care was made and this information was circulated to all the organizations, requesting them to identify activities which could be further strengthened or developed. A good response has been received and this effort is generating a further exchange of information and collaboration in programmes. Close coordination has been maintained with UNICEF through the UNICEF/WHO Joint Committee on Health Policy for the development of action in support of primary health care. Contacts have been maintained and/or strengthened with several geopolitical groupings of countries that transcend regional boundaries, in support of the Strategy. At the global level formal contacts have been established with the Group of 77, the non-aligned countries, the Commonwealth Secretariat, the European Economic Community, the Council for Mutual Economic Assistance, the Organization of the Islamic Conference, and the Council of Ministers of Health of the Arab Gulf States. Support for the Strategy is being promoted through these contacts, both political as well as financial.

143. The attainment of the goal of health for all by the year 2000 is intimately related to socioeconomic development and a commitment to world peace. In response to a request of the Thirty-fourth World Health Assembly,2 with a view to intensifying WHO's contribution to the socioeconomic development of countries and the preservation and promotion of peace, the Director-General set up an authoritative multidisciplinary international committee to study

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1 Document WHA33/1980/REC/1, Annex 4, Appendix.

2 Resolution WHA34.38 on "The role of physicians and other health workers in the preservation and promotion of peace as the most significant factor for the attainment of health for all".
comprehensively the threat that thermonuclear war constitutes for the life and health of peoples of the world. The conclusion in the Committee's report, which was endorsed by the Thirty-sixth World Health Assembly, was that it is impossible to prepare health services to deal in any systematic way with a catastrophe resulting from nuclear warfare, and that nuclear weapons constitute the greatest immediate threat to the health and welfare of mankind. The Health Assembly recommended that the Organization, in cooperation with other United Nations agencies, continue the work of collecting, analysing and regularly publishing accounts of activities and further studies on the effects of nuclear war on health and health services, keeping the Health Assembly informed. The Assembly also endorsed another report of the Committee which emphasized the need to ensure that economic growth actually benefits people and that health aspects are taken into consideration in social and economic development planning.

144. The nongovernmental organizations were recently reviewed to identify those whose programmes focus more directly on primary health care. The thrust of WHO's effort is to strengthen the collaboration of these organizations at the national level in support of national strategies for health for all. Several steps have been identified in this process in interested countries. WHO has assisted in the compilation of information on the nongovernmental organizations involved in health and health-related activities. It has thus supported consultations between the government and the organizations' representatives at the national level, to foster mutual understanding and collaborative activities in support of national strategies. Several countries have taken such initiatives (Bolivia, India, the Netherlands, Nigeria, Sri Lanka, Sudan and Thailand). WHO's support will be further extended in this area to promote the exchange of information and experience between governments and nongovernmental organizations, and among the organizations themselves, and an integrated approach to health development at the national level.

IV. CONCLUSIONS AND FUTURE OUTLOOK

145. The strategies and plans of action have received national, regional and global attention, and the Member States and Secretariat have been active in their formulation and implementation. Intensified follow-up of the implementation process is now required. It is noted that about a quarter of the Member States have not submitted their progress reports and many of the reports submitted were not as complete or accurate as they should have been. At the regional and global levels, synthesis and consolidation of the available information lends itself only to a very general overall assessment of the progress being achieved. The present report also suffers from a lack of detailed and precise information on many of the important aspects which are crucial to the national strategies. Furthermore, it indicates that implementation of the Strategy and its monitoring have not proceeded as rapidly as desirable.

146. The common framework and format has played a generally positive role in facilitating reporting. However, in view of the difficulties experienced by some of the countries in its application as well as in providing information on the 12 global indicators adopted by the Thirty-fourth World Health Assembly, it is necessary to refine and improve the monitoring tools. An analysis of what problems exist at national level in the interpretation of the indicators and in the collection and analysis of the relevant data should be carried out with a view to improving the monitoring of the implementation of the strategies. Clear explanatory notes also need to be given to facilitate the utilization of the global indicators by countries.

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2 See resolution WHA36.28 (document WHA36/1983/REC/1, p. 25).

3 The contribution of health to socioeconomic development (document A36/13).
147. The principle of full national participation on a cross-sectoral basis is the keystone to the implementation of the Strategy for Health for All. The report indicates that a high level of political sensitization appears to have taken place and many countries have initiated the processes of formulating their national policies, strategies and plans for the achievement of the goal of health for all by the year 2000. While health policies appear to be oriented to achieve greater coverage of the population through primary health care, it is not clear whether this is adequately reflected in national sociopolitical and economic development policies. Health is only one aspect of development and social equity can be achieved only through simultaneous action in many sectors. Available information does not indicate that health is yet receiving a high priority in the allocation of national resources in spite of the adoption of national policies for health for all by the year 2000 at the highest political level. Member States are again urged to assume their full responsibility for the implementation of their strategies in order to achieve the universally accepted goal of health for all by the year 2000, and take the necessary action to mobilize full support from all relevant sectors.

148. Many countries still have to formulate detailed plans of action with specific objectives, targets and a projection of resources for the achievement of these objectives. Ideally these plans should be for a long-term period (up to the year 2000) with short-term and medium-term targets. Implicit in this is a review of existing resources, an analysis of overall needs, and plans for mobilization of these resources from national and external sources. Very few countries appear to have accomplished this and most find it difficult to estimate the resources now going to their health sector. An in-depth review is needed to identify what constraints exist and what specific actions should be taken to improve the utilization and distribution of existing resources and to generate additional resources, especially from other sectors, in support of health.

149. Several countries appear to be making efforts to review and reorient their health systems and to train health manpower to extend primary health care services. Available information is inadequate to assess how effective these efforts have been in achieving improved coverage of the population, and what constraints or difficulties are being experienced in bringing about any changes. Several crucial issues still remain largely unresolved. Among these are: the establishment of effective linkages among the different levels of health care delivery systems so that they are really supportive to primary health care; effective coordination of technical programmes, especially the essential elements of primary health care which are to be delivered through health systems; planning and training of health manpower consonant with the needs of the health system; and achievement of real changes in the attitudes and values of health workers in support of the goal of social equity. National capabilities for carrying out a suitable managerial process for health development, including the collection, analysis and utilization of information in support of the process, require further strengthening. This is an area where WHO should intensify its technical cooperation, particularly with those Member States that are fully committed to achieving the goal of health for all.

150. National experience in stimulating a greater degree of community involvement and participation of other sectors in health appears to point to the need for real decentralization and delegation of authority to the intermediate and local levels of health administration and the communities. Some countries have made no or very little effort to involve the communities or have found it difficult to involve other sectors effectively. What policy constraints exist in these areas which need to be resolved? Little information has been provided by the countries on their efforts to improve the health literacy of their populations. Without adequate understanding and sustained motivation on the part of individuals, families and communities in dealing with their own health matters, the goal of health for all is not likely to be achieved. It is obvious that much more effort is needed in these areas, and countries can also gain from sharing their experience, technologies and resources with others.

151. The reports indicate a trend towards increased cooperation among countries, particularly in the promotion of efforts which will stimulate national health development action to support primary health care and tackle priority health problems affecting a large number of people in the countries. While sharing of information and technical know-how are important, transfer
of financial resources from the richer to the poorer countries, and especially the least developed ones, is even more critical if the latter are to make significant progress towards achieving the goal of health for all. Available information does not permit an assessment of trends in this area. Monitoring of these resources will be important to reflect trends as well as to ensure that they are being channelled to priority health problems and to extend primary health care to hitherto underserved and underprivileged population groups.

152. Information provided on action at national, regional and global levels in support of the national strategies shows that the Organization has largely met its responsibilities to date with respect to providing guiding principles to facilitate the process of implementing the strategies. Serious efforts are now required to implement these principles in a practical manner in the countries. The Organization should intensify its support to the countries in applying them and further improve and modify them as necessary on the basis of the experience gained in the course of their implementation. The need for guidance for research aimed at health development in line with the strategies for health for all is also evident. It is noted that the efforts of Member States, WHO's governing bodies and the Secretariat in the development, implementation and monitoring of the strategies for health for all are being coordinated. The participation of the governing bodies in reviewing and reorienting WHO's programme and functions has also been active. They need to devote continuing and serious efforts to the monitoring and evaluation processes, as indicated by a review of this progress report and the discussions and observations of the regional committees. WHO should also further strengthen its role as coordinator of international health work with respect to organizations of the United Nations system so as to facilitate wherever applicable combined technical cooperation activities, primarily at the country level but also at regional and global levels, in support of the implementation of national strategies for health for all.

153. It is felt that, in spite of its limitations, the process has yielded useful information on the efforts of governments to implement their national strategies for health for all by the year 2000. What is even more important at this stage is that a process for monitoring progress at national, regional and global levels has been set in motion. Through concerted efforts to improve information systems at the national level, this process could in the future yield more valuable data and support the development of managerial processes at the national level and within WHO. Improved data will also help in analysing factors which are facilitating or impeding the development of national strategies and suggest areas for supportive or developmental action which would enhance and facilitate national health development processes. Hence the importance of careful monitoring of progress at the national level and the need for Member States to assume full responsibility for and to give high priority to the monitoring and evaluation processes in support of their national strategies for health for all cannot be overemphasized.
ANALYSIS OF THE 12 GLOBAL INDICATORS

1. The common framework and format used by national health managers for the monitoring of their national strategies contained a list of 12 global indicators adopted at the Thirty-fourth World Health Assembly together with the Global Strategy for Health for All, with relevant definitions and elements to be considered in generating and presenting these indicators. Global indicators were selected from a long list prepared by WHO in response to a request by the Executive Board. In addition to the 12 global indicators, countries and WHO regions were encouraged to select and adopt national and regional indicators relevant to their specific situation.

2. National progress reports prepared in accordance with the common framework and format were forwarded by 122 Member States to their respective regional offices, that is, about three-quarters of those that were expected. This part of the report will present mainly the information reported by Member States using the common framework and format.

GLOBAL INDICATOR 1

3. Global indicator 1 has been defined as the number of countries in which: "Health for all has received endorsement as policy at the highest official level".

4. One hundred and seven countries answered this question, i.e., 88% of those which sent a progress report; 103 answered positively, 2 stated that a partial endorsement had been received, and 2 answered negatively.

GLOBAL INDICATOR 2

5. Global indicator 2 has been defined as the number of countries in which: "Mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning".

6. Ninety-seven countries provided information on this indicator; 78 answered yes, 2 indicated a partial involvement, and 17 mentioned that no participation was taking place.

7. The following table shows the results obtained by WHO regions:

<table>
<thead>
<tr>
<th>WHO region</th>
<th>Number of countries</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With available information</td>
<td>With involvement of people</td>
</tr>
<tr>
<td>Africa</td>
<td>25</td>
<td>23</td>
</tr>
<tr>
<td>Americas</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Europe</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>97</td>
<td>78</td>
</tr>
</tbody>
</table>

---

8. Three global indicators were adopted to evaluate resource allocation and distribution:

- gross national product (GNP) per head;
- the percentage of the gross national product spent on health;
- the percentage of the national health expenditure devoted to local health care.

GLOBAL INDICATOR 12

9. Global indicator 12 is defined as the number of countries in which: "The gross national product per head exceeds US$ 500."

10. One hundred and one countries provided quantitative information. Some countries provided the gross domestic product (GDP) per capita instead of GNP per capita. It is important to note that out of 122 countries that sent a progress report, 21 were not in a position to indicate a value for this indicator.

11. The following table shows the distribution of GNP (GDP) per capita by WHO region.

<table>
<thead>
<tr>
<th>GNP per head</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AFR</td>
<td>AMR</td>
</tr>
<tr>
<td>Less than $ 100</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>$ 100- 199</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>$ 200- 299</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>$ 300- 399</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>$ 400- 499</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>$ 500- 999</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>$ 1000-1999</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>$ 2000-2999</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>$ 3000-3999</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>$ 4000-4999</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>$ 5000-5999</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>$ 6000-6999</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>$ 7000-7999</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>$ 8000-8999</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>$ 9000-9999</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>$ 10 000 or more</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Subtotal</td>
<td>36</td>
<td>16</td>
</tr>
<tr>
<td>Without data or data disqualified</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>No progress reports</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>31</td>
</tr>
</tbody>
</table>

a If GNP was not available, countries used GDP and GDP at factor cost.

12. When the US$ 500 threshold is applied, it is found that 61 countries have a GNP per capita exceeding the limit, i.e., some 60% of those answering the question. From the above table some regional variations can be noted. The figures should be seen and interpreted with care. Other international organizations are currently publishing similar information with a higher coverage. It seems appropriate to recommend a greater exchange of information between national health authorities and the economic and financial sector.
GLOBAL INDICATOR 3

13. Global indicator 3 is closely related to the previous one and is defined as the number of countries in which: "At least 5% of the gross national product is spent on health".

14. Some countries experienced difficulties in measuring the percentage of their GNP spent on health. GNP itself is not always available for recent years, as mentioned above. It seems that many countries have not yet developed an appropriate mechanism for estimating financial resources spent on health. Some countries took into account only government expenditures and omitted the private sector, if any, or ignored the contributions made by the community or local authorities. However, 63 countries provided an estimated percentage. The following table shows the distribution of Member States by region according to the percentage of GNP spent on health.

<table>
<thead>
<tr>
<th>Percentage of GNP spent on health</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AFR</td>
<td>AMR</td>
</tr>
<tr>
<td>Less than 1.0%</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>1.0-1.9%</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2.0-2.9%</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>3.0-3.9%</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>4.0-4.9%</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>5.0-5.9%</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>6.0-6.9%</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>7.0-7.9%</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>8.0-8.9%</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>9.0-9.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>10.0% or more</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Subtotal</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Without data or data disqualified</td>
<td>23</td>
<td>9</td>
</tr>
<tr>
<td>No progress report</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>31</td>
</tr>
</tbody>
</table>

- Government expenditure on health only.
- Including resources received by the developing countries from more affluent countries.

15. The indicator specifies a reference value of 5%. The following table shows by WHO regions the percentage of countries spending at least 5% of their GNP on health.
**THIRTY-SEVENTH WORLD HEALTH ASSEMBLY**

**Percentage of countries with at least 5% of their GNP spent on health**

<table>
<thead>
<tr>
<th>WHO region</th>
<th>Number of countries</th>
<th>With available information</th>
<th>With at least 5% of GNP spent on health</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>14</td>
<td>4</td>
<td>28.6</td>
<td></td>
</tr>
<tr>
<td>Americas</td>
<td>10</td>
<td>3</td>
<td>30.0</td>
<td></td>
</tr>
<tr>
<td>South-East Asia</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Europe</td>
<td>15</td>
<td>14</td>
<td>93.3</td>
<td></td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>13</td>
<td>2</td>
<td>15.4</td>
<td></td>
</tr>
<tr>
<td>Western Pacific</td>
<td>7</td>
<td>3</td>
<td>42.9</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>63</td>
<td>26</td>
<td>41.3</td>
<td></td>
</tr>
</tbody>
</table>

16. Information is available for 63 countries. Of those countries only 26 spent more than 5% of their GNP on health. Regional variations are shown above. Because of the low percentage of answers received and the difficulty experienced by countries in estimating health expenditure, it is not possible at this stage to formulate any general conclusions.

**GLOBAL INDICATOR 4**

17. Global indicator 4 is defined as the number of countries in which: "A reasonable percentage of the national health expenditure is devoted to local health care".

18. The formulation of the indicator implies the knowledge in each country of the percentage of the health expenditure spent at local level. At this stage no clear definition of "reasonable percentage" can be provided as a reference value, and hence this report takes into consideration only the distribution of the percentage indicated in the national analysis. Information on this indicator was provided by 50 countries, as shown below.

**Number of countries reporting on global indicator 4**

<table>
<thead>
<tr>
<th>WHO region</th>
<th>Number of countries</th>
<th>With progress report</th>
<th>Reporting indicator</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>37</td>
<td>14</td>
<td>37.8</td>
<td></td>
</tr>
<tr>
<td>Americas</td>
<td>19</td>
<td>2</td>
<td>10.5</td>
<td></td>
</tr>
<tr>
<td>South-East Asia</td>
<td>11</td>
<td>6</td>
<td>54.5</td>
<td></td>
</tr>
<tr>
<td>Europe</td>
<td>21</td>
<td>9</td>
<td>42.9</td>
<td></td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>22</td>
<td>11</td>
<td>50.0</td>
<td></td>
</tr>
<tr>
<td>Western Pacific</td>
<td>12</td>
<td>8</td>
<td>66.7</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>122</td>
<td>50</td>
<td>41.0</td>
<td></td>
</tr>
</tbody>
</table>

19. The distribution of the percentages of health budget devoted to local health care is shown in the following table. Comments made earlier on the difficulties faced by the countries in collecting and integrating information on health expenditure are also valid for this indicator.
### Percentage of the national health expenditure devoted to local health care

<table>
<thead>
<tr>
<th>Percentage of national health expenditure</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AFR</td>
<td>AMR</td>
</tr>
<tr>
<td>Less than 10.0%</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>10.0-19.9%</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>20.0-29.9%</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>30.0-39.9%</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>40.0-49.9%</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>50.0-59.9%</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>60.0-69.9%</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>70.0% or more</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Subtotal</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Without data or data disqualified</td>
<td>23</td>
<td>17</td>
</tr>
<tr>
<td>No progress report</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>31</td>
</tr>
</tbody>
</table>

20. Because of the lack of precise national definition of the meaning of "reasonable percentage", it is not possible to calculate the global indicator as was anticipated. The above table shows that about half of the countries that answered spend 30% or more of their national health expenditure on local care.

**GLOBAL INDICATOR 5**

21. Global indicator 5 is defined as the number of countries in which: "Resources are equitably distributed".

22. The material provided by countries is rather heterogeneous. Some countries answered by a yes/no statement, others formulated quantitative replies indicating the number of inhabitants for selected health professions or various types of institutions. Without precise criteria for measuring the equity of the distribution of resources, it is not possible to interpret globally the information provided. Research should be undertaken in the near future on that aspect of the Strategy and some guidelines should be available before the next evaluation reporting in 1985 and 1986.

**GLOBAL INDICATOR 6**

23. Global indicator 6 in the Global Strategy is defined as: "The number of developing countries with well-defined strategies for health for all, accompanied by explicit resource allocations, whose needs for external resources are receiving sustained support from more affluent countries".

24. Out of the 161 Member States and Associate Members (in mid-1983), 124 are considered as developing countries. The remaining 37, considered as developed countries, are located in three WHO regions - 2 in the Americas, 3 in the Western Pacific, and 32 in Europe. Only a few of the 124 expected contributions reached the regional offices. As already mentioned, countries are still in the process of formulating their national strategies and the related resource allocations have not yet been fully worked out. Thirty-three countries answered positively, but at this stage it is not possible to measure with any precision how the needs for external support are being met. In practice all developing countries are receiving some support from other countries; how far this support is in line with the national strategy remains to be assessed.
GLOBAL INDICATOR 7

25. Global indicator 7 is defined as the number of countries in which: "Primary health care is available to the whole population, with at least the following:

- safe water in the home or within 15 minutes' walking distance, and adequate sanitary facilities in the home or immediate vicinity;
- immunization against diphtheria, tetanus, whooping-cough, measles, poliomyelitis, and tuberculosis;
- local health care, including availability of at least 20 essential drugs, within one hour's walk or travel;
- trained personnel for attending pregnancy and childbirth, and caring for children up to at least 1 year of age."

26. Global indicator 7 thus comprises sub-indicators related to each of the above elements and will be reported below accordingly.

Sub-indicators on environmental hygiene

27. Two sub-indicators, to assess the availability of safe water and adequate sanitary facilities, were reported by countries.

(a) Percentage of the population with safe water available in the home or within 15 minutes' walking distance.

28. Sixty-two countries provided information on the availability of safe water. Some did this separately for urban and rural areas, but this breakdown has not been included in the present analysis. In future the possibility of such a breakdown will be envisaged. The following table shows the distribution of coverage of safe water by WHO region as reported by Member States according to the common framework and format.

<table>
<thead>
<tr>
<th>Proportion of population for whom safe water is available</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AFR</td>
<td>AMR</td>
</tr>
<tr>
<td>Less than 10.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.0-19.9%</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>20.0-29.9%</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>30.0-39.9%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>40.0-49.9%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>50.0-59.9%</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>60.0-69.9%</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>70.0-79.9%</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>80.0-89.9%</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>90.0% or more</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Subtotal</td>
<td>13</td>
<td>18</td>
</tr>
<tr>
<td>Without data or data disqualified</td>
<td>24</td>
<td>1</td>
</tr>
<tr>
<td>No progress report</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>31</td>
</tr>
</tbody>
</table>
ANNEX 3

(b) Percentage of population with adequate sanitary facilities available in the home or immediate vicinity.

29. Only 52 countries provided values at national level for this indicator. The same remarks made on availability of safe water apply, namely, the need to envisage a breakdown by urban and rural areas for the future. Out of these 52 countries, 15 countries (29%) indicated a coverage of 90% or more of the total population with adequate sanitary facilities. The following table shows the distribution of countries by region according to the coverage.

Adequate sanitary facilities in the home or immediate vicinity

<table>
<thead>
<tr>
<th>Proportion of population for whom adequate sanitary facilities are available</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AFR</td>
<td>AMR</td>
</tr>
<tr>
<td>Less than 10.0%</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>10.0-19.9%</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>20.0-29.9%</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30.0-39.9%</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>40.0-49.9%</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>50.0-59.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>60.0-69.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>70.0-79.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>80.0-89.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>90.0% or more</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Subtotal</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Without data or data disqualified</td>
<td>28</td>
<td>5</td>
</tr>
<tr>
<td>No progress report</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>31</td>
</tr>
</tbody>
</table>

30. The number of countries reporting information for the above two sub-indicators is low. It is not possible at this stage to explain the reasons for this poor coverage; it is hoped that measures can be taken at country level to improve collection of the data.

Sub-indicators on selected immunizations

31. Concerning immunization against diphtheria, tetanus, whooping-cough, measles, poliomyelitis and tuberculosis, the common framework and format defined four sub-indicators:

Proportion of infants under 1 year of age who have been fully immunized against:

- diphtheria, tetanus, and whooping-cough (3 doses)
- measles (1 dose)
- poliomyelitis (3 doses)
- tuberculosis (1 dose)

32. The information provided by countries that forwarded progress reports was rather heterogeneous. Information was not reported or available in accordance with the specifications of the indicator. The following global figures were obtained.
### Number of countries reporting on immunization

<table>
<thead>
<tr>
<th>Immunization against</th>
<th>Number of countries</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With progress report</td>
<td>Reporting immunization coverage</td>
</tr>
<tr>
<td>Diphtheria, tetanus and whooping-cough</td>
<td>122</td>
<td>52</td>
</tr>
<tr>
<td>Measles</td>
<td>122</td>
<td>43</td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td>122</td>
<td>50</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>122</td>
<td>29</td>
</tr>
</tbody>
</table>

33. The following tables show the distribution of countries which provided progress reports, according to the immunization coverage for each of the four groups of diseases.

#### Immunization against diphtheria, tetanus and whooping-cough

<table>
<thead>
<tr>
<th>Proportion of infants under 1 year immunized</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AFR</td>
<td>AMR</td>
</tr>
<tr>
<td>Less than 10.0%</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>10.0-19.9%</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>20.0-29.9%</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>30.0-39.9%</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>40.0-49.9%</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>50.0-59.9%</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>60.0-69.9%</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>70.0-79.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>80.0-89.9%</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>90.0% or more</td>
<td>-</td>
<td>3</td>
</tr>
</tbody>
</table>

**Subtotal** | 11 | 17 | 3 | 7 | 10 | 4 | 52 |

**Without data or data disqualified** | 26 | 2 | 8 | 14 | 12 | 8 | 70 |

**No progress report** | 7 | 12 | - | 14 | 1 | 5 | 39 |

**Total** | 44 | 31 | 11 | 35 | 23 | 17 | 161 |
## Immunization against measles

<table>
<thead>
<tr>
<th>Proportion of infants under 1 year immunized</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AFR</td>
<td>AMR</td>
</tr>
<tr>
<td>Less than 10.0%</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>10.0–19.9%</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>20.0–29.9%</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>30.0–39.9%</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>40.0–49.9%</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>50.0–59.9%</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>60.0–69.9%</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>70.0–79.9%</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>80.0–89.9%</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>90.0% or more</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Without data or data disqualified</td>
<td>28</td>
<td>5</td>
</tr>
<tr>
<td>No progress report</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>44</td>
<td>31</td>
</tr>
</tbody>
</table>

## Immunization against poliomyelitis

<table>
<thead>
<tr>
<th>Proportion of infants under 1 year immunized</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AFR</td>
<td>AMR</td>
</tr>
<tr>
<td>Less than 10.0%</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>10.0–19.9%</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>20.0–29.9%</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>30.0–39.9%</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>40.0–49.9%</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>50.0–59.9%</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>60.0–69.9%</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>70.0–79.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>80.0–89.9%</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>90.0% or more</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>Without data or data disqualified</td>
<td>27</td>
<td>3</td>
</tr>
<tr>
<td>No progress report</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>44</td>
<td>31</td>
</tr>
</tbody>
</table>
### Immunization against tuberculosis

<table>
<thead>
<tr>
<th>Proportion of infants under 1 year immunized</th>
<th>AFR</th>
<th>AMR</th>
<th>SEAR</th>
<th>EUR</th>
<th>EMR</th>
<th>WPR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10.0%</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>10.0-19.9%</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>20.0-29.9%</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>30.0-39.9%</td>
<td>1</td>
<td>N.A.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>40.0-49.9%</td>
<td>1</td>
<td>N.A.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>50.0-59.9%</td>
<td>1</td>
<td>N.A.</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>60.0-69.9%</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>70.0-79.9%</td>
<td>1</td>
<td>N.A.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>80.0-89.9%</td>
<td>2</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>1</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>90.0% or more</td>
<td>1</td>
<td>N.A.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>12</td>
<td>N.A.</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>3</td>
<td>29</td>
</tr>
<tr>
<td><strong>Without data or data disqualified</strong></td>
<td>25</td>
<td>19</td>
<td>8</td>
<td>17</td>
<td>15</td>
<td>9</td>
<td>93</td>
</tr>
<tr>
<td><strong>No progress report</strong></td>
<td>7</td>
<td>12</td>
<td>14</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>39</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>44</td>
<td>31</td>
<td>11</td>
<td>35</td>
<td>23</td>
<td>17</td>
<td>161</td>
</tr>
</tbody>
</table>

*A The information provided does not permit this indicator to be tabulated.

### Sub-indicators on local health care

34. The proportion of the population having access to local health care, including availability of at least 20 essential drugs, within one hour's walk or travel, was to be reported. Forty-five countries (incomplete, since no information is available from the Americas) have provided usable information. The following table shows the actual results obtained.

#### Availability of local health care

<table>
<thead>
<tr>
<th>Proportion of population for whom local health care is available</th>
<th>AFR</th>
<th>AMR</th>
<th>SEAR</th>
<th>EUR</th>
<th>EMR</th>
<th>WPR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>10.0-19.9%</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>20.0-29.9%</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>30.0-39.9%</td>
<td>1</td>
<td>N.A.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>40.0-49.9%</td>
<td>2</td>
<td>N.A.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>50.0-59.9%</td>
<td>-</td>
<td>N.A.</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>60.0-69.9%</td>
<td>1</td>
<td>N.A.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>70.0-79.9%</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>80.0-89.9%</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>90.0% or more</td>
<td>4</td>
<td>3</td>
<td>10</td>
<td>8</td>
<td>-</td>
<td>25</td>
<td>45</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>14</td>
<td>N.A.</td>
<td>3</td>
<td>10</td>
<td>14</td>
<td>4</td>
<td>45</td>
</tr>
<tr>
<td><strong>Without data or data disqualified</strong></td>
<td>23</td>
<td>19</td>
<td>8</td>
<td>11</td>
<td>8</td>
<td>8</td>
<td>77</td>
</tr>
<tr>
<td><strong>No progress report</strong></td>
<td>7</td>
<td>12</td>
<td>-</td>
<td>14</td>
<td>1</td>
<td>5</td>
<td>39</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>44</td>
<td>31</td>
<td>11</td>
<td>35</td>
<td>23</td>
<td>17</td>
<td>161</td>
</tr>
</tbody>
</table>

*A The information provided does not permit this indicator to be tabulated.*
35. From the above table it may be noted that 25 countries indicated that 90% or more of the population have access to local care with at least 20 essential drugs. Of those countries, 10 are located in the European Region.

Sub-indicators on availability of trained personnel

36. Two sub-indicators have been defined:

- proportion of women attended during pregnancy and childbirth by trained personnel;

- proportion of children aged under 1 year cared for by trained personnel.

37. Provisional information is shown in the following tables. Apart from the Region of the Americas, 37 countries provided information for the attendance of pregnant women and 22 countries for the care of infants under 1 year of age. At this stage of the data analysis, it would be premature to infer any conclusion on the coverages. Reasons for non-response should be investigated and possible remedies suggested.

Availability of trained personnel for attending pregnancy and childbirth

<table>
<thead>
<tr>
<th>Proportion of women attended during pregnancy and childbirth</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AFR</td>
<td>AMR(^a)</td>
</tr>
<tr>
<td>Less than 10.0%</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>10.0-19.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>20.0-29.9%</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>30.0-39.9%</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>40.0-49.9%</td>
<td>-</td>
<td>N.A.</td>
</tr>
<tr>
<td>50.0-59.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>60.0-69.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>70.0-79.9%</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>80.0-89.9%</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>90.0% or more</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Subtotal</td>
<td>12</td>
<td>N.A.</td>
</tr>
<tr>
<td>Without data or data disqualified</td>
<td>25</td>
<td>19</td>
</tr>
<tr>
<td>No progress report</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>31</td>
</tr>
</tbody>
</table>

\(^a\) The information provided does not permit this indicator to be tabulated.
### Availability of trained personnel to care for children up to at least 1 year of age

<table>
<thead>
<tr>
<th>Proportion of children aged under 1 year cared for</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>APR(^a)</td>
<td>AMR(^a)</td>
</tr>
<tr>
<td>Less than 10.0%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>10.0-19.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>20.0-29.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>30.0-39.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>40.0-49.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>50.0-59.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>60.0-69.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>70.0-79.9%</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>80.0-89.9%</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>90.0% or more</td>
<td>N.A.</td>
<td>N.A.</td>
</tr>
<tr>
<td>Subtotal</td>
<td>N.A.</td>
<td>N.A.</td>
</tr>
</tbody>
</table>

Without data or data disqualified

| Subtotal | N.A. | N.A. | 3 | 10 | 7 | 2 | 22 |

No progress report

| Subtotal | 37 | 19 | 8 | 11 | 15 | 10 | 100 |

Total

| Subtotal | 44 | 31 | 11 | 35 | 23 | 17 | 161 |

\(^a\) The information provided does not permit this indicator to be tabulated.

### GLOBAL INDICATOR 8

38. **Global indicator 8** is defined as the number of countries in which: "The nutritional status of children is adequate, in that:

- at least 90% of newborn infants have a birth weight of at least 2500 g;
- at least 90% of children have a weight for age that corresponds to the reference values given in Annex 1 to Development of indicators for monitoring progress towards health for all by the year 2000".\(^1\)

39. The two sub-indicators are dealt with separately below. Fifty-two countries provided information about birth weight and 14 only on weight for age of children under 5 years. The following tables present the distribution of countries for each of the two sub-indicators. The poor response rate does not allow for valid conclusions.

---

\(^1\) Op. cit.
# Birth weight of at least 2500 g

<table>
<thead>
<tr>
<th>% of newborn infants with birth weight of at least 2500 g</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AFR</td>
<td>AMR</td>
</tr>
<tr>
<td>Less than 10.0%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>10.0-19.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>20.0-29.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>30.0-39.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>40.0-49.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>50.0-59.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>60.0-69.9%</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>70.0-79.9%</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>80.0-89.9%</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>90.0% or more</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Subtotal</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Without data or data disqualified</td>
<td>26</td>
<td>18</td>
</tr>
<tr>
<td>No progress report</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>31</td>
</tr>
</tbody>
</table>

# Weight for age of children under 5 years

<table>
<thead>
<tr>
<th>% of children under 5 years corresponding to the reference values</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AFR</td>
<td>AMRa</td>
</tr>
<tr>
<td>Less than 10.0%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>10.0-19.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>20.0-29.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>30.0-39.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>40.0-49.9%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>50.0-59.9%</td>
<td>-</td>
<td>N.A.</td>
</tr>
<tr>
<td>60.0-69.9%</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>70.0-79.9%</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>80.0-89.9%</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>90.0% or more</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Subtotal</td>
<td>4</td>
<td>N.A.</td>
</tr>
<tr>
<td>Without data or data disqualified</td>
<td>33</td>
<td>19</td>
</tr>
<tr>
<td>No progress report</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>31</td>
</tr>
</tbody>
</table>

a The information provided does not permit this indicator to be tabulated.
GLOBAL INDICATOR 9

40. Global indicator 9 is defined as the number of countries in which: "The infant mortality rate for all identifiable subgroups is below 50 per 1000 live births".

41. Infant mortality rate is the number of deaths of infants under the age of one year per 1000 live births in a given year. This is known to be a sensitive indicator of impacts of health programmes and of the status of health care. Member States were requested, in monitoring the implementation of their national strategies, to provide the latest information available at national level and also for identified subgroups of population.

42. Out of 122 national reports received, 112 countries provided information on infant mortality at national level. The distribution by WHO region is shown in the following table. In general no indication was provided in the national progress reports as to whether the infant mortality rate was calculated or estimated. For some countries the reference period was old, which may reflect the difficulty experienced by many developing countries in estimating this indicator. Disaggregation for identified groups of population was not reported by most countries. It is not therefore possible in the present analysis to provide ranges and to highlight discrepancies within a country.

<table>
<thead>
<tr>
<th>Infant mortality (deaths under 1 year per 1000 liveborn)</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AFR</td>
<td>AMR</td>
</tr>
<tr>
<td>Less than 10.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>10.0-19.9</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>20.0-29.9</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>30.0-39.9</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>40.0-49.9</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>50.0-59.9</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>60.0-69.9</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>70.0-79.9</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>80.0-89.9</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>90.0-99.9</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>100.0-149.9</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>150.0-199.9</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>200.0 or more</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Subtotal</td>
<td>37</td>
<td>19</td>
</tr>
<tr>
<td>Without data or data disqualified</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>No progress report</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>31</td>
</tr>
</tbody>
</table>

43. With reference to the threshold mentioned for this indicator in the Global Strategy (50 infant deaths for 1000 live births), 49 Member States out of 112 (43.8%) have a level of infant mortality below 50 deaths per 1000 live births. There is a great variation between WHO regions. The following table shows the percentage of countries with an infant mortality rate (IMR) lower than 50 deaths per 1000 live births. In the African Region, 81.1% of the reporting countries have an IMR higher than 100 infant deaths per 1000 live births.
Percentage of countries with an infant mortality rate below 50 per 1000

<table>
<thead>
<tr>
<th>WHO region</th>
<th>Number of countries</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reporting IMR</td>
<td>With IMR below 50 per 1000</td>
</tr>
<tr>
<td>Africa</td>
<td>37</td>
<td>3</td>
</tr>
<tr>
<td>Americas</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Europe</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>112</strong></td>
<td><strong>49</strong></td>
</tr>
</tbody>
</table>

44. As mentioned in some national and regional reports, efforts should be made in collaboration with national civil registration offices to improve the national capability and/or to apply alternative methodologies to generate data required in the construction of this indicator.

GLOBAL INDICATOR 10

45. **Global indicator 10** is defined as the number of countries in which: "Life expectancy at birth is over 60 years".

46. One hundred and eleven countries out of 122 provided this information. No indication was given how life expectancy was calculated. For some countries national values may also be rather obsolete. The following table shows the distribution of countries, by WHO region.

**Life expectancy at birth**

<table>
<thead>
<tr>
<th>Life expectancy at birth (in years)</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AFR</td>
<td>AMR</td>
</tr>
<tr>
<td>Less than 40.0</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>40.0-49.9</td>
<td>24</td>
<td>2</td>
</tr>
<tr>
<td>50.0-59.9</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>60.0-69.9</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>70.0 or more</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>36</strong></td>
<td><strong>18</strong></td>
</tr>
<tr>
<td>Without data or data disqualified</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No progress report</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

47. With reference to the threshold fixed at 60 years, the following table shows the results obtained in each WHO region.
Percentage of countries with life expectancy ($e^0$) of over 60 years

<table>
<thead>
<tr>
<th>WHO region</th>
<th>Number of countries</th>
<th>$%$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With available info</td>
<td>With $e^0$ over 60 yrs</td>
</tr>
<tr>
<td>Africa</td>
<td>36</td>
<td>2</td>
</tr>
<tr>
<td>Americas</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Europe</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>111</strong></td>
<td><strong>53</strong></td>
</tr>
</tbody>
</table>

48. Out of 111 countries, 53 have a life expectancy of over 60 years. Only two countries in Africa have reached that level (5.6% of responding countries).

GLOBAL INDICATOR 11

49. Global indicator 11 is defined as the number of countries in which: "The adult literacy rate for both men and women exceeds 70%".

50. Progress towards health for all is likely to be strongly influenced by education. The adult literacy rate was included in the list of global indicators as an indicator of the contribution of education to health. This rate was defined as the percentage of the population aged 15 and over able to read and write in any language.

51. Out of 122 countries that sent in progress reports, 84 provided quantitative information on adult literacy. Thus, 31% of the countries sending progress reports did not provide this information. Moreover, most countries did not separate the rates for males and females as required. The following table shows the distribution of countries according to the adult literacy rate by WHO region.

<table>
<thead>
<tr>
<th>Adult literacy rate</th>
<th>Number of countries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AFR</td>
<td>AMR</td>
</tr>
<tr>
<td>Less than 10.0%</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>10.0-19.9%</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>20.0-29.9%</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>30.0-39.9%</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>40.0-49.9%</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>50.0-59.9%</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>60.0-69.9%</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>70.0-79.9%</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>80.0-89.9%</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>90.0% or more</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>Without data or data disqualified</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>No progress report</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>44</td>
<td>31</td>
</tr>
</tbody>
</table>
52. The Global Strategy suggested a threshold of 70% for this rate. The following table shows the number of countries by WHO region having reached that level.

### Percentage of countries with a literacy rate higher than 70%

<table>
<thead>
<tr>
<th>WHO region</th>
<th>Number of countries</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With available info</td>
<td>With literacy over 70%</td>
</tr>
<tr>
<td>Africa</td>
<td>21</td>
<td>4</td>
</tr>
<tr>
<td>Americas</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Europe</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>84</strong></td>
<td><strong>48</strong></td>
</tr>
</tbody>
</table>

53. Intersectoral collaboration in data generation and exchange with education and social services should be promoted by countries which are not yet in a position to obtain and use this type of information. On the international side, the provision of the necessary technical cooperation from UNESCO may be called for.

**DISCUSSION ON THE FINDINGS**

54. One Member State out of four did not send its national report on monitoring progress on time. Furthermore, some of the reports received did not contain the requested national values for the global indicators adopted by the World Health Assembly. It is therefore apparent that for certain essential indicators Member States were not in a position to provide the information.

55. During the discussions of the subject at the regional committee sessions in September/October 1983, Member States adopted resolutions proposing that they collectively develop and further improve their monitoring and evaluation systems and reorient and strengthen their national information support.

56. Among the recommendations made at those sessions, WHO was requested to increase its support to Member States in order to develop national mechanisms for generating essential information. Training of national and WHO staff was also requested, especially in management and information support.

57. The relevance of global indicators was reviewed during the regional committees' discussions. In the light of these discussions the mechanisms for the collection, analysis and interpretation of the global indicators may be improved for the evaluation reports due in 1985 at national and regional levels.

58. In order to measure differences within a country, it will be necessary for health authorities to establish mechanisms to collect information at regional, provincial, or district levels for quantified indicators. The same principles could also apply to different socio-economic groups in the population.
2. COMMENTS BY THE DIRECTOR-GENERAL

[EB73/4 - 15 December 1983]

I. INTRODUCTION

1. In May 1982, when the Thirty-fifth World Health Assembly approved the Plan of Action for implementing the Global Strategy for Health for All, it also called for collective action by Member States, the governing bodies of WHO and the Secretariat to monitor progress and to evaluate its effectiveness at periodic intervals. In accepting the principle of monitoring their efforts and their progress towards achieving the goal of health for all, the Member States made a sound and courageous decision. Through the monitoring process, they will identify what obstacles are encountered in the implementation of their strategies, confront issues requiring additional action, and ask themselves crucial questions.

2. It takes courage to enter into this process. The move from words to deeds is never easy. The governments have collectively endorsed the goal of health for all by the year 2000, and so, implicitly accepted what needs to be done to achieve that goal. Guiding principles to facilitate the process are available, but there can be no universal blueprint for their implementation. Thus each country must put these principles into action and, through "learning by doing", find out how this goal can be achieved. The monitoring effort is essential at the national, regional and global levels to determine whether we are making progress and also to ask searching questions. For example, we may want to ask ourselves such questions as: can we make better progress; can we learn from each other's experiences; what obstacles still lie in our way; what assumptions were wrong; and what corrective action needs to be taken? The process is primarily important within each country, as a tool for improving the development, functioning and evaluation of the corresponding national health system. Health development calls for intersectoral action, which implies that monitoring the progress of implementation of the Strategy must be an intersectoral process. Ideally, it should also develop from the bottom up, so that national monitoring reports are derived from intersectoral monitoring activities carried out at all levels of each country's structures.

3. The results of monitoring depend upon the seriousness with which these necessary tasks are carried out and the importance given to the process as a whole. If this responsibility is not exercised in the spirit in which it was accepted, then the monitoring will become a gigantic exercise in bureaucracy - a mere collection and compilation of "information" on a "WHO questionnaire" every two years. Unless the process is seriously implemented at the national level where the information is compiled, analysed and used to review progress, to identify constraints and to take corrective action, it is meaningless, as it will not really contribute to the development of national strategies for health for all. It is important that governments strengthen their monitoring capacities and determine how best they can jointly discuss their achievements, problems and solutions on a regional basis, for example, in the regional committees.

II. REVIEW OF PROGRESS

4. What does the progress report\(^2\) indicate at this stage? It appears that a high level of political sensitization has taken place and the political will to achieve the goal of

\(^1\) The Board's discussion is reflected in the summary records of its session; see document EB73/1984/REC/2, pp. 68, 74, 85 and 138.

\(^2\) See part 1 of this annex.
health for all exists in a large majority of the countries that have reported. National health policies have been or are being formulated with the aim of achieving universal coverage of the population through primary health care. Countries are beginning to look at their national health systems with a view to reorienting them to the primary health care approach and to redistributing resources to strengthen their community-based health services. Important efforts have been initiated to train or reorient health workers towards primary health care. The right and duty of people to participate in developing their country's health system has been officially recognized in a large majority of the reporting countries and several are trying various measures to bring about that involvement. Efforts to stimulate other relevant sectors to undertake intersectoral action in health have also been initiated in a few countries. One can also discern a trend towards increased intercountry cooperation in health, especially in sharing information and technical know-how and in reaching agreements on priority health problems.

5. While these in themselves are important achievements in this short time, a number of observations on the relative lack of progress may also be made. Few countries seem to have developed well-defined plans of action for carrying out their strategies which include specific targets and objectives, a time-frame, and data on the projection and allocation of resources. Even fewer countries can assess the resource flow from national and external sources to support their strategies. This leads one to assume that the countries either do not have adequate information to back up their planning and managerial processes, or have not developed the managerial capacities of their health systems sufficiently to utilize the available information.

6. While the overall response rate is good (122 out of 161 Member States have reported), the completeness and the quality of information leave much to be desired. This also raises the question how much effort was really made at the national level to review the information that was sent to the regional offices, or to make this information known to those who might be able to use it, or to identify real issues and constraints in the implementation of the national strategies and propose action to resolve them? Or did countries treat the common framework and format (document DGO/82.1) as "just another WHO questionnaire"?

7. How seriously did the regional committees review these reports? The deliberations and conclusions of some of the regional committees did not give an indication of what constraints have been identified in the implementation of the national strategies; what can be done to resolve them; what serious gaps exist; and what corrective or supportive action may be required. They do not tell us what significant or important lessons have been learned or what experience may have been gained which can be shared by other countries.

8. At the global level, consolidation of the reports tends to smooth over the findings and the conclusions, and it is difficult to reflect the wide variations among countries and the regions. Also, the contents of the report can only be as specific as the regional and the country reports.

9. One important observation, however, must be made: that there is a striking lack of information to analyse even some of the critical aspects related to the implementation of the strategies. It is difficult to say at this stage whether such information is not available in countries or whether inadequate efforts have been made to collect and analyse data that actually are available. The gaps in the information provided by the countries on national values for the 12 global indicators which were agreed upon by them are examples of these deficiencies. Some of the countries were unable to provide information on the most critical indicator of the health status of their population - the infant mortality rate. In a few countries, the data provided differed from the data available through other governmental sources. Few were able to provide information on the current coverage of their population with such components of primary health care as water supply, maternal care during pregnancy, and immunization against the six communicable diseases (diphtheria, tetanus, whooping-cough, measles, poliomyelitis and tuberculosis). It seems that countries have been able to provide more complete information on these same indicators when it has been specifically collected by the WHO programmes concerned. This raises the question of the validity and reliability of information.

10. Another critical area is the information on the resources, especially the financial resources, currently available for health. Many countries encountered serious difficulties when attempting to determine the proportion of their GNP spent on health, and even more could not estimate the percentage of the national health expenditure spent on primary health care. Even developed countries failed to secure this information. This raises several
questions. Is this information available to national health authorities? If not, on what economic basis are countries planning their national strategies? How are the national objectives and targets being defined? How are countries making decisions on the allocation of health resources, and especially the increase of resources for primary health care? These become even more complex issues when the countries must also consider the contribution of other health-related sectors to health. This is an area which will require further supportive and developmental action from WHO.

III. FUTURE OUTLOOK

11. Do we then have grounds for optimism or pessimism in our future course towards the implementation of the strategies for health for all? In spite of its limitations, we can state that the monitoring process has yielded useful information, even at this early stage, on the efforts governments are making towards the implementation of their national strategies. What is even more important is that a process for monitoring the progress at national, regional and global levels has been set in motion. But much more concerted effort is required to maintain momentum and even accelerate the pace of our actions to implement the strategies.

12. Monitoring of implementation and evaluation of effectiveness and impact must take place not only at the policy level but also at the managerial/technical levels, and these two have to be interlinked. Information is an essential ingredient of the monitoring and evaluation, which is also linked to the managerial processes for national health development. Information on health problems and trends is required to enable policy-makers and managers to identify priorities for the formulation of national health policies. Information on the availability and distribution of health resources is required to identify variations, gaps, and adjustments needed to ensure equitable distribution, and to indicate additional resource requirements. Information on the type of technologies and services available and being utilized is needed to identify gaps in coverage of the population, to determine what reorientation of the health system is needed, and to assess relative cost-effectiveness. It cannot, therefore, be over-emphasized that the strengthening of the managerial capacities of national health systems (with particular emphasis on the development of planning and managerial processes backed up by adequate information system support and trained personnel) must receive priority attention in the countries and in WHO's collaborative activities. Guiding principles for the strengthening of the managerial processes of the health systems and the evaluation of health programmes have been developed which need to be appropriately adapted and effectively used at the national level.

13. There is no doubt that, in their efforts to implement their national strategies, countries are going to have to experiment with new ideas and approaches, especially those aimed at improving coverage for underserved or disadvantaged population groups, increasing community involvement, utilizing more appropriate and cost-effective technologies, and promoting effective intersectoral action in health. Ministries of health generally lack the capacity to carry out operational research on such issues and to orient their health administrators and health workers in the application of the outcomes of such research. National capacities in health systems research and development require strengthening, and in this area the role and strengthening of relevant national and regional institutions should be considered. Research and development, however, must be intimately linked with the managerial processes so that any lessons learned from such research can be immediately applied and, in addition, the issues on which further knowledge is required are identified by the health administrators themselves.

14. And finally, the countries must give serious consideration to where WHO's support would be most useful and how its resources at the national level can be used optimally for the development and implementation of national strategies. The new managerial framework for the optimal use of WHO's resources provides an opportunity for governments to put the Strategy for Health for All into practice. This framework for technical cooperation between WHO and its Member States focuses on the Organization's support to national health policies that comply with international policies adopted in WHO. It involves joint government/WHO policy and programme reviews to this end, as well as coherent and coordinated responses to countries' needs as identified through this process from all other levels of the Organization. The whole weight of the Organization's total resources - political, moral,

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1 A managerial framework for optimal use of WHO's resources in direct support of Member States (document DGO/83.1).
technical, as well as financial - has to be brought to bear on the mainstream of national health development activities. The responsibility to ensure that the fundamental principles of the new managerial framework are actually adhered to, and to make optimal use of what WHO has to offer by directing its support to areas which would enhance national health development, clearly rests with the Member States and the governing bodies of WHO.

IV. CONCLUDING COMMENT

15. Was it too early to start this monitoring process which was aimed, not at just collecting information, but at identifying the progress made and the relevant issues which affect the implementation of the strategies and which need to be further addressed? Not if we have only 16 years ahead of us to reach the goal we have set for ourselves. We need to identify factors together which are facilitating or impeding the development of national health systems and areas to which supportive, developmental and corrective action can be directed to enable countries to make accelerated progress in their march towards health for all. We also need to learn how to improve the monitoring and evaluation processes so that they yield information which is useful at national level for assessing progress and the effectiveness of particular actions in the implementation of the strategies, and at international levels for learning together from countries' experience and for modifying our course as necessary. In 1985 we will begin the first evaluation of the strategies for health for all. All measures must be introduced now to strengthen the capacity of countries to evaluate their health systems through a systematic process that leads to improving current activities, promotes better planning, and yields the information required to assess the impact of the strategies and to indicate what action is needed in all sectors of government, as well as in various sectors at international level.
<table>
<thead>
<tr>
<th>Preparation</th>
<th>IU per ampoule</th>
<th>ng/μl (if relevant)</th>
<th>Form in which available</th>
<th>Years of establishment (in brackets, weight of previous standard containing one IU)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTIBIOTICS</strong> (held in London)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphotericin B</td>
<td>-</td>
<td>0.001064</td>
<td>Ampoules containing approximately 50 mg of amphotericin B (960 IU per mg)</td>
<td>1st Standard 1963</td>
</tr>
<tr>
<td>Bacitracin</td>
<td>-</td>
<td>0.01351</td>
<td>Ampoules containing approximately 100 mg of zinc bacitracin (74 IU per mg)</td>
<td>1st Standard 1953 (0.0182 mg)</td>
</tr>
<tr>
<td>Chlorotetracycline</td>
<td>-</td>
<td>0.001</td>
<td>Ampoules containing approximately 75 mg of chlorotetracycline hydrochloride (1000 IU per mg)</td>
<td>1st Standard 1953 (0.001 mg)</td>
</tr>
<tr>
<td>Colistin</td>
<td>-</td>
<td>0.00006487</td>
<td>Ampoules containing approximately 75 mg of colistin sulfate (20 500 IU per mg)</td>
<td>1st Standard 1968</td>
</tr>
<tr>
<td>Dihydrostreptomycin</td>
<td>-</td>
<td>0.001219</td>
<td>Ampoules containing approximately 200 mg of dihydrostreptomycin sulfate (820 IU per mg)</td>
<td>1st Standard 1953 (0.001316 mg)</td>
</tr>
<tr>
<td>Erythromycin</td>
<td>-</td>
<td>0.001087</td>
<td>Ampoules containing approximately 75 mg of erythromycin A base (920 IU per mg)</td>
<td>1st Standard 1957 (0.001053 mg)</td>
</tr>
<tr>
<td>Novobiocin</td>
<td>-</td>
<td>0.001031</td>
<td>Ampoules containing approximately 100 mg of novobiocin acid (720 IU per mg)</td>
<td>1st Standard 1965</td>
</tr>
<tr>
<td>Nystatin</td>
<td>-</td>
<td>0.0002039</td>
<td>Ampoules containing approximately 100 mg of nystatin (4555 IU per mg)</td>
<td>1st Standard 1963 (0.000333 mg)</td>
</tr>
<tr>
<td>Oleandomycin</td>
<td>-</td>
<td>0.001176</td>
<td>Ampoules containing approximately 75 mg of oleandomycin chloroform adduct (850 IU per mg)</td>
<td>1st Standard 1964</td>
</tr>
<tr>
<td>Oxytetracycline</td>
<td>-</td>
<td>0.001364</td>
<td>Ampoules containing approximately 100 mg of oxytetracycline base dihydrate (1d0 IU per mg)</td>
<td>1st Standard 1955 (0.00111 mg)</td>
</tr>
<tr>
<td>Polymyxin B</td>
<td>-</td>
<td>0.000119</td>
<td>Ampoules containing approximately 75 mg of purified polymyxin B sulfate (8403 IU per mg)</td>
<td>1st Standard 1955 (0.000127 mg)</td>
</tr>
<tr>
<td>Rolitetracycline</td>
<td>-</td>
<td>0.001004</td>
<td>Ampoules containing approximately 100 mg of rolitetracycline (9% IU per mg)</td>
<td>1st Standard 1968</td>
</tr>
<tr>
<td>Streptomycin</td>
<td>78 500</td>
<td>-</td>
<td>Ampoules containing 100 mg of streptomycin sulfate</td>
<td>1st Standard 1950 (0.001282 mg)</td>
</tr>
<tr>
<td>Tetracycline</td>
<td>-</td>
<td>0.00101833</td>
<td>Ampoules containing approximately 75 mg of tetracycline hydrochloride (982 IU per mg)</td>
<td>1st Standard 1957 (0.00101 mg)</td>
</tr>
<tr>
<td>Vancomycin</td>
<td>-</td>
<td>0.000395</td>
<td>Ampoules containing approximately 50 mg of vancomycin sulfate (1007 IU per mg)</td>
<td>1st Standard 1963</td>
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<td><strong>ANTIBIOTICS</strong> (held in Weybridge, England)</td>
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<td></td>
</tr>
<tr>
<td>Hygromycin B</td>
<td>-</td>
<td>0.0008928</td>
<td>Ampoules containing 40 mg of hygromycin B (1120 IU per mg)</td>
<td>1st Standard 1966</td>
</tr>
<tr>
<td>Tylosin</td>
<td>-</td>
<td>0.001</td>
<td>Ampoules containing 40 mg of tylosin base (1000 IU per mg)</td>
<td>1st Standard 1966</td>
</tr>
<tr>
<td><strong>ANTIBODIES</strong> (held in Copenhagen)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Anti-dysentery serum (Shiga), equine</td>
<td>-</td>
<td>0.05</td>
<td>Bottles containing 10 ml of a solution of dried hyperimmune horse serum in saline containing 66% v/v of glycerol (200 IU per ml)</td>
<td>1st Standard 1928</td>
</tr>
<tr>
<td>Anti-poliovirus serum (type 1), monkey</td>
<td>10</td>
<td>-</td>
<td>Ampoules containing 107.8 mg of dried hyperimmune monkey serum</td>
<td>1st Standard 1962</td>
</tr>
<tr>
<td>Anti-poliovirus serum (type 2), monkey</td>
<td>10</td>
<td>-</td>
<td>Ampoules containing 104.6 mg of dried hyperimmune monkey serum</td>
<td>1st Standard 1962</td>
</tr>
<tr>
<td>Anti-poliovirus serum (type 3), monkey</td>
<td>10</td>
<td>-</td>
<td>Ampoules containing 104.8 mg of dried hyperimmune monkey serum</td>
<td>1st Standard 1962</td>
</tr>
<tr>
<td>Anti-Q-fever serum, bovine</td>
<td>1 000</td>
<td>0.1017</td>
<td>Ampoules containing 101.7 mg of dried bovine serum (1% 12%)</td>
<td>1st Standard 1953</td>
</tr>
<tr>
<td>Anti-rabies serum, equine</td>
<td>86.6</td>
<td>1.0</td>
<td>Ampoules containing 86.6 mg of dried hyperimmune horse serum (1% 5.3%)</td>
<td>1st Standard 1955</td>
</tr>
<tr>
<td>Anti-smallpox serum, human</td>
<td>1 000</td>
<td>-</td>
<td>Ampoules containing 85.3 mg of frozen-dried pooled human serum</td>
<td>1st Standard 1965</td>
</tr>
<tr>
<td>Anti-streptolysin O, human</td>
<td>2 150</td>
<td>-</td>
<td>Ampoules containing 44 mg of dried human serum; distributed as a 10 ml solution containing 10 IU per ml</td>
<td>1st Standard 1959</td>
</tr>
</tbody>
</table>

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ANNEX 4

INTERNATIONAL STANDARDS AND UNITS FOR BIOLOGICAL SUBSTANCES

LIST I. BIOLOGICAL STANDARDS

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1 See resolution WHA37.27. The full addresses from which international reference materials may be obtained are published in: Biological substances: International Standards, Reference Preparations, and Reference Reagents, Geneva, World Health Organization, 1984 (in press). The two lists contained in this annex include standards and reference preparations established up to 1982.
### LIST I. BIOLOGICAL STANDARDS (continued)

<table>
<thead>
<tr>
<th>Preparation</th>
<th>IU per ampoule</th>
<th>mg/IU (if relevant)</th>
<th>Form in which available</th>
<th>Years of establishment (in brackets, weight of previous standard containing one IU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-toxoplasma serum, human</td>
<td>2 000</td>
<td>-</td>
<td>Ampoules containing 175.8 mg of freeze-dried pooled human serum</td>
<td>1st Standard 1967, 2nd Standard 1980</td>
</tr>
<tr>
<td>Clostridium botulinum Type A antitoxin, equine</td>
<td>500</td>
<td>-</td>
<td>Ampoules containing 68.0 mg of dried hyperimmune horse serum</td>
<td>1st Standard 1963</td>
</tr>
<tr>
<td>Clostridium botulinum Type B antitoxin, equine</td>
<td>500</td>
<td>-</td>
<td>Ampoules containing 87.0 mg of dried hyperimmune horse serum</td>
<td>1st Standard 1963</td>
</tr>
<tr>
<td>Clostridium botulinum Type C antitoxin, equine</td>
<td>1 000</td>
<td>-</td>
<td>Ampoules containing 80.0 mg of dried hyperimmune horse serum</td>
<td>1st Standard 1963</td>
</tr>
<tr>
<td>Clostridium botulinum Type D antitoxin, equine</td>
<td>1 000</td>
<td>-</td>
<td>Ampoules containing 12.1 mg of dried hyperimmune horse serum</td>
<td>1st Standard 1963</td>
</tr>
<tr>
<td>Clostridium botulinum Type E antitoxin, equine</td>
<td>1 000</td>
<td>-</td>
<td>Ampoules containing 69.1 mg of dried hyperimmune horse serum</td>
<td>1st Standard 1963</td>
</tr>
<tr>
<td>Clostridium botulinum Type F antitoxin, rabbit</td>
<td>4</td>
<td>-</td>
<td>Ampoules containing 29.32 mg of dried hyperimmune rabbit serum</td>
<td>1st Standard 1965</td>
</tr>
<tr>
<td>Diphtheria antitoxin, equine</td>
<td>- 0.0628</td>
<td>(of dry material in stock ampoules)</td>
<td>Ampoules containing approximately 476 mg of dried hyperimmune horse serum; distributed in bottles containing 10 ml of solution of the dried serum containing 66% v/v of glycerol (10 IU per ml)</td>
<td>1st Standard 1935 (0.3575 mg), 2nd Standard 1951 (0.2 mg), 3rd Standard 1971</td>
</tr>
<tr>
<td>Gas-gangrene antitoxin (Clostridium histolyticum), equine</td>
<td>50</td>
<td>0.2</td>
<td>Ampoules containing 10.0 mg of freeze-dried hyperimmune horse serum</td>
<td>1st Standard 1937, 2nd Standard 1961</td>
</tr>
<tr>
<td>Gas-gangrene antitoxin (Clostridium novyi), equine</td>
<td>1 100</td>
<td>-</td>
<td>Ampoules containing 91 mg of dried hyperimmune horse serum</td>
<td>1st Standard 1934 (0.2681 mg), 2nd Standard 1952 (0.1135 mg), 3rd Standard 1966</td>
</tr>
<tr>
<td>Gas-gangrene antitoxin (Clostridium septicum), equine</td>
<td>500</td>
<td>0.118</td>
<td>Ampoules containing 59 mg of a dried 1:3 dilution of hyperimmune horse serum in phosphate-buffered saline</td>
<td>1st Standard 1934 (0.2377 mg), 2nd Standard 1967 (0.0974 mg), 3rd Standard 1957</td>
</tr>
<tr>
<td>Gas-gangrene antitoxin (Clostridium sordelli), equine</td>
<td>- 0.334</td>
<td>(of dry material in stock ampoules)</td>
<td>Bottles containing 10 ml of a solution of dried hyperimmune horse serum in saline containing 66% v/v of glycerol (20 IU per ml)</td>
<td>1st Standard 1938</td>
</tr>
<tr>
<td>Gas-gangrene antitoxin (Clostridium perfringens alpha antitoxin), equine</td>
<td>270</td>
<td>-</td>
<td>Ampoules containing 90.35 mg of dried hyperimmune horse serum</td>
<td>1st Standard 1931 (0.3220 mg), 2nd Standard 1955 (0.2660 mg), 3rd Standard 1963 (0.3477 mg), 4th Standard 1953 (0.1112 mg), 5th Standard 1963</td>
</tr>
<tr>
<td>Naja antivenin, equine</td>
<td>300</td>
<td>2.69</td>
<td>Ampoules containing 807 mg of purified, dried, polyvalent (Naja and Hemachatus species) horse serum</td>
<td>1st Standard 1964</td>
</tr>
<tr>
<td>Scarlet fever streptococcus antitoxin, equine</td>
<td>10 000</td>
<td>0.059</td>
<td>Ampoules containing 490 mg of dried hyperimmune horse serum</td>
<td>1st Standard 1952</td>
</tr>
<tr>
<td>Staphylococcus 0x antitoxin, equine</td>
<td>220</td>
<td>-</td>
<td>Ampoules containing 93.7 mg of freeze-dried hyperimmune horse serum</td>
<td>1st Standard 1934 (0.5000 mg), 2nd Standard 1938 (0.2376 mg), 3rd Standard 1982</td>
</tr>
<tr>
<td>Syphilitic serum, human</td>
<td>49</td>
<td>-</td>
<td>Ampoules containing 177.4 mg of dried human serum</td>
<td>1st Standard 1958</td>
</tr>
<tr>
<td>Tetanus antitoxin, equine</td>
<td>1 400 (1000 IU equivalents for flocculation)</td>
<td>-</td>
<td>Ampoules containing 47 mg of freeze-dried hyperimmune horse serum (1400 IU per ampoule)</td>
<td>1st Standard 1928 (0.3094 mg), 2nd Standard 1969</td>
</tr>
</tbody>
</table>

---

1 The history of the standard is not entirely clear. Apparently (Chill, Health Organ. Int. 1939) a standard existed since 1922 but there is no information on the way in which it was defined. The present standard was prepared in Copenhagen in 1938 and is the first one with a clearly defined unitage.

2 Valid equivalent for the synonym Clostridium cedematiens, which the International Committee on Systematic Bacteriology has now declared invalid (Int. J. System. Bacteriol., 30: 225 (1980)).

3 Valid equivalent for (perfringens) Clostridium welchii type A antitoxin — see previous footnote.

4 This serum is also suitable for flocculation. The in vivo to in vitro ratio is 1.4; therefore for practical purposes it may be assumed that the ampule contains 1000 IU-equivalents.
### LIST I: BIOLOGICAL STANDARDS (continued)

<table>
<thead>
<tr>
<th>Preparation</th>
<th>IU per ampoule</th>
<th>mgIU (if relevant)</th>
<th>Form in which available</th>
<th>Years of establishment (in brackets, weight of previous standard containing one IU)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTIBODIES</strong> (held in Weybridge, England) (continued)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-Salmonella pullorum serum (Standard Form I)</td>
<td>1 000</td>
<td>-</td>
<td>Ampoules containing 83.8 mg of freeze-dried goat serum prepared against a standard English field strain (strain 11)</td>
<td>1st Standard 1973</td>
</tr>
<tr>
<td>Anti-Salmonella pullorum serum (Variant Form IV)</td>
<td>1:000</td>
<td>-</td>
<td>Ampoules containing 81.4 mg of freeze-dried goat serum prepared against an American variant strain</td>
<td>1st Standard 1973</td>
</tr>
<tr>
<td>Anti-swine-fever serum</td>
<td>1 000</td>
<td>-</td>
<td>Ampoules containing 889.5 mg of freeze-dried pig serum</td>
<td>1st Standard 1963</td>
</tr>
<tr>
<td>Clostridium perfringens beta-antitoxin</td>
<td>5 000</td>
<td>-</td>
<td>Ampoules containing 68.5 mg of dried hyperimmune horse serum</td>
<td>1st Standard 1954</td>
</tr>
<tr>
<td>Clostridium perfringens epsilon-antitoxin</td>
<td>1 000</td>
<td>-</td>
<td>Ampoules containing 65.7 mg of dried hyperimmune horse serum</td>
<td>1st Standard 1954</td>
</tr>
<tr>
<td>Swine erysipelas serum (anti.B)</td>
<td>628</td>
<td>-</td>
<td>Ampoules containing 87.9 mg of dried hyperimmune horse serum</td>
<td>1st Standard 1954</td>
</tr>
<tr>
<td><strong>ANTIGENS</strong> (held in Copenhagen)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria toxoid, adsorbed</td>
<td>132</td>
<td>-</td>
<td>Ampoules containing 75 mg of diphtheria toxoid adsorbed on aluminium hydroxide (1.0 mg AI/ampoule) plus polygeline (26 mg per ampoule)</td>
<td>1st Standard 1955 (0.75 mg) 2nd Standard 1978</td>
</tr>
<tr>
<td>Diphtheria toxoid, plain</td>
<td>200</td>
<td>-</td>
<td>Ampoules containing 21 mg of formalin-treated diphtheria toxoid, freeze-dried</td>
<td>1st Standard 1951 (0.50 mg) 2nd Standard 1975</td>
</tr>
<tr>
<td>Diphtheria (Schick) test toxin</td>
<td>900</td>
<td>-</td>
<td>Ampoules containing 0.005 mg of purified diphtheria toxicin plus 1 mg of bovine albumin and 2.74 mg of phosphate buffer salts</td>
<td>1st Standard 1954</td>
</tr>
<tr>
<td>Tetanus toxoid, adsorbed</td>
<td>340</td>
<td>-</td>
<td>Ampoules containing 27.5 mg of a dried mixture of tetanus toxoid (90 IU/ampoule), adsorbed to aluminium hydroxide (1 mg AI³/ampoule) and 22.5 mg of haemacel</td>
<td>1st Standard 1965 2nd Standard 1981</td>
</tr>
<tr>
<td>Tetanus toxoid, plain</td>
<td>833</td>
<td>0.03</td>
<td>Ampoules containing 25 mg of alcohol-purified tetanus toxoid plain plus glycine</td>
<td>1st Standard 1951</td>
</tr>
<tr>
<td>Tuberculin, old</td>
<td>-</td>
<td>-</td>
<td>Ampoules containing 2 ml of old tuberculin (90 000 IU per ml)</td>
<td>1st Standard 1931 (0.0100 µl) 2nd Standard 1935 (0.0100 µl) 3rd Standard 1965</td>
</tr>
<tr>
<td>Tuberculin, purified protein derivative (PPD), avian</td>
<td>500 000</td>
<td>0.0000726</td>
<td>Ampoules containing 10 mg of PPD plus 26.3 mg of salts</td>
<td>1st Standard 1954</td>
</tr>
<tr>
<td>Tuberculin, purified protein derivative (PPD), mammalian</td>
<td>500 000</td>
<td>0.000028</td>
<td>Ampoules containing 10 mg of PPD prepared from a human strain plus 4 mg of salts</td>
<td>1st Standard 1951</td>
</tr>
</tbody>
</table>

**AN/TID/39 (held in Weybridge, England)**

<table>
<thead>
<tr>
<th>Preparation</th>
<th>IU per ampoule</th>
<th>mgIU (if relevant)</th>
<th>Form in which available</th>
<th>Years of establishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle disease vaccine (inactivated)</td>
<td>525</td>
<td>-</td>
<td>Ampoules containing 525 mg of freeze-dried vaccine derived from formaldehyde-treated allantoic fluid of eggs infected with strains of Newcastle disease virus, adsorbed on aluminium hydroxide</td>
<td>1st Standard 1963</td>
</tr>
<tr>
<td>Swine erysipelas vaccine</td>
<td>1 000</td>
<td>-</td>
<td>Ampoules containing 499 mg of dried vaccine derived from formaldehyde-treated Erysipelothrix rhusiopathiae type B, adsorbed on aluminium hydroxide</td>
<td>1st Standard 1959</td>
</tr>
</tbody>
</table>

**BLOOD PRODUCTS AND RELATED SUBSTANCES** (held in London)

<table>
<thead>
<tr>
<th>Preparation</th>
<th>IU per ampoule</th>
<th>mgIU (if relevant)</th>
<th>Form in which available</th>
<th>Years of establishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heparin, porcine</td>
<td>1 370</td>
<td>-</td>
<td>Ampoules containing approximately 8.0 mg of sodium heparin from porcine intestinal mucosa, freeze-dried</td>
<td>1st Standard 1962 (0.0077 mg) 2nd Standard 1976 (0.0077 mg) 3rd Standard 1973</td>
</tr>
</tbody>
</table>

1 Valid equivalents for synonym Cl. welchii (perfringens) types B and D antitoxins, which the International Committee on Systematic Bacteriology has now declared invalid (Int. J. System. Bacteriol., 30: 225 (1980)).
### LIST 1. BIOLOGICAL STANDARDS (continued)

<table>
<thead>
<tr>
<th>Preparation</th>
<th>IU per ampoule</th>
<th>mg/IU (if relevant)</th>
<th>Form in which available</th>
<th>Years of establishment (in brackets, weight of previous standard containing one IU)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BLOOD PRODUCTS AND RELATED SUBSTANCES (held in London) (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Streptokinase and streptodornase</td>
<td></td>
<td></td>
<td>Ampoules containing approximately 1 mg of extract with 5 mg of lactose, freeze-dried</td>
<td>1st Standard 1964</td>
</tr>
<tr>
<td>Streptokinase</td>
<td>3 100</td>
<td>-</td>
<td></td>
<td>1st Standard 1975</td>
</tr>
<tr>
<td>Streptodornase</td>
<td>2 400</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thrombin, human</td>
<td>100</td>
<td>-</td>
<td>Ampoules containing approximately 1.5 mg of partially purified freeze-dried human thrombin and 5 mg sucrose</td>
<td>1st Standard 1978</td>
</tr>
<tr>
<td><strong>BLOOD PRODUCTS AND RELATED SUBSTANCES (held in Copenhagen)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alphafetoprotein, human</td>
<td>100 000</td>
<td>-</td>
<td>Ampoules containing 139.91 mg of freeze-dried cord serum</td>
<td>1st Standard 1975</td>
</tr>
<tr>
<td><strong>BLOOD PRODUCTS AND RELATED SUBSTANCES (held in Amsterdam)</strong></td>
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<tr>
<td>Anti-A blood-typing serum, human</td>
<td>32</td>
<td>-</td>
<td>Ampoules containing approximately 30 mg of dried material derived from 0.5 ml of pooled human serum</td>
<td>1st Standard 1966</td>
</tr>
<tr>
<td>FITC-conjugated sheep anti-human Ig</td>
<td>100</td>
<td>-</td>
<td>Ampoules containing 5.94 mg of sheep anti-human Ig, freeze-dried</td>
<td>1st Standard 1975</td>
</tr>
<tr>
<td>FITC-conjugated sheep anti-human IgG</td>
<td>100</td>
<td>-</td>
<td>Ampoules containing 6.47 mg of freeze-dried sheep anti-human IgG</td>
<td>1st Standard 1977</td>
</tr>
<tr>
<td>FITC-conjugated sheep anti-human IgG (anti-(\gamma) chain)</td>
<td>100</td>
<td>-</td>
<td>Ampoules containing 9.23 mg of freeze-dried sheep anti-human IgG, anti-(\gamma) chain</td>
<td>1st Standard 1981</td>
</tr>
<tr>
<td>Anti-A blood-typing serum, human</td>
<td>670</td>
<td>-</td>
<td>Ampoules containing approximately 99.9 mg of dried material derived from 1 ml of human serum</td>
<td>1st Standard 1950</td>
</tr>
<tr>
<td>Anti-B blood-typing serum, human</td>
<td>860</td>
<td>-</td>
<td>Ampoules containing approximately 83.0 mg of dried material derived from 1 ml of human serum</td>
<td>2nd Standard 1980</td>
</tr>
<tr>
<td>Anti-A,B blood-typing serum, human</td>
<td>400</td>
<td>Anti-A</td>
<td>Ampoules containing approximately 93.3 mg of dried material derived from 1 ml of human serum</td>
<td>1st Standard 1981</td>
</tr>
<tr>
<td>Anti-B blood-typing serum, human</td>
<td>240</td>
<td>Anti-B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-(\upsilon) incomplete, blood-typing serum, human</td>
<td>64</td>
<td>-</td>
<td>Ampoules containing 34.0 mg of freeze-dried human anti-(\upsilon) blood-typing serum diluted in AB serum</td>
<td>1st Standard 1976</td>
</tr>
</tbody>
</table>

### ENDOCRINOLGICAL AND RELATED SUBSTANCES (held in London)

<table>
<thead>
<tr>
<th>Preparation</th>
<th>IU per ampoule</th>
<th>mg/IU (if relevant)</th>
<th>Form in which available</th>
<th>Years of establishment (in brackets, weight of previous standard containing one IU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arginine vasopressin, for bioassay</td>
<td>8.2</td>
<td>-</td>
<td>Ampoules containing approximately 20 μg of freeze-dried synthetic arginine vasopressin peptide acetate with 5 mg human albumin and citric acid</td>
<td>1st Standard 1978</td>
</tr>
<tr>
<td>Chorionic gonadotrophin, human, for bioassay</td>
<td>5 300</td>
<td>-</td>
<td>Ampoules containing approximately 2 mg of freeze-dried extract of chorionic gonadotrophin from human urine of pregnancy, with 5 mg lactose</td>
<td>1st Standard 1939 (0.1 mg)</td>
</tr>
<tr>
<td>Corticotrophin (ACTH), porcine, for bioassay</td>
<td>5.0</td>
<td>-</td>
<td>Ampoules containing approximately 50 μg of freeze-dried corticotrophin from the anterior lobes of porcine pituitary glands, with 5 mg lactose</td>
<td>1st Standard 1950 (1.00 mg)</td>
</tr>
<tr>
<td>Desmopressin</td>
<td>27</td>
<td>-</td>
<td>Ampoules containing approximately 27 μg of (1,3)-mercapto-L-proline acid-(\beta,\beta)-argininevasopressin,(^1) with 5 mg of human albumin and citric acid</td>
<td>1st Standard 1980</td>
</tr>
<tr>
<td>Glucagon, porcine, for bioassay</td>
<td>1.49</td>
<td>-</td>
<td>Ampoules containing approximately 1.5 mg of freeze-dried porcine glucagon, with 5 mg lactose and sodium chloride</td>
<td>1st Standard 1973</td>
</tr>
<tr>
<td>Growth hormone, bovine, for bioassay</td>
<td>-</td>
<td>1.0</td>
<td>Ampoules containing approximately 30 mg of dried growth hormone from bovine pituitary glands</td>
<td>1st Standard 1955</td>
</tr>
<tr>
<td>Insulin, bovine and porcine, for bioassay</td>
<td>-</td>
<td>0.04167</td>
<td>Ampoules containing approximately 110 mg of insulin, cocrystallized from a mixture of 52% bovine and 48% porcine insulin (24.0 IU per mg)</td>
<td>1st Standard 1925 (0.12300 mg)</td>
</tr>
<tr>
<td>Kininogenase, porcine, pancreatic</td>
<td>22.5</td>
<td>-</td>
<td>Ampoules containing approximately 20 μg of freeze-dried porcine pancreatic kininogenase with 5 mg human albumin</td>
<td>1st Standard 1982</td>
</tr>
<tr>
<td>Lysine vasopressin</td>
<td>7.7</td>
<td>-</td>
<td>Ampoules containing approximately 23.4 μg of freeze-dried synthetic lysine vasopressin, with 5 mg albumin and citric acid</td>
<td>1st Standard 1978</td>
</tr>
</tbody>
</table>

\(^1\) Formerly known as 1-desmino-\(\beta,\beta\)-argininevasopressin.
### THIRTY-SEVENTH WORLD HEALTH ASSEMBLY

**LIST I. BIOLOGICAL STANDARDS (continued)**

<table>
<thead>
<tr>
<th>Preparation</th>
<th>IU per ampoule</th>
<th>mg/UI (if relevant)</th>
<th>Form in which available</th>
<th>Years of establishment (in brackets, weight of previous standard containing one IU)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ENDOCRINOLOGICAL AND RELATED SUBSTANCES</strong> (held in London) (continued)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxytocin, for bioassay</td>
<td>12.5</td>
<td>-</td>
<td>Ampoules containing approximately 21.4 mg of dried synthetic oxytocin peptide with 5 mg human albumin and citric acid</td>
<td>4th Standard 1978</td>
</tr>
<tr>
<td>Prolactin, ovine, for bioassay</td>
<td>-</td>
<td>0.04545</td>
<td>Ampoules containing approximately 10 mg of freeze-dried purified prolactin from sheep pituitary glands (22.0 IU/mg)</td>
<td>1st Standard 1939 (0.1 mg)</td>
</tr>
<tr>
<td>Serum gonadotrophin, equine, for bioassay</td>
<td>1 600</td>
<td>-</td>
<td>Ampoules containing approximately 0.8 mg of freeze-dried extract from the serum of pregnant mares, with 5 mg lactose</td>
<td>1st Standard 1939 (0.25 mg)</td>
</tr>
<tr>
<td>Thyrotrophin (pituitary TSH), bovine, for bioassay</td>
<td>-</td>
<td>13.5</td>
<td>Ampoules containing 10 tablets of approximately 20 mg of a blend of 1 part of purified thyrotrophin from bovine pituitary glands and 19 parts of lactose</td>
<td>1st Standard 1954</td>
</tr>
<tr>
<td>Urinary FSH and LH (ICSH), human, for bioassay</td>
<td>-</td>
<td>54.0 (FSH) 46.0 (LH)</td>
<td>Ampoules containing approximately 1 mg of freeze-dried extract of urine from post-menopausal women, with 5 mg of lactose</td>
<td>1st Standard 1974</td>
</tr>
<tr>
<td><strong>MISCELLANEOUS</strong> (held in London)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digitalis</td>
<td>-</td>
<td>75.0</td>
<td>Bottles containing approximately 2300 mg of dry powdered leaves of <em>Digitalis purpurea</em> (0.01116 IU per mg)</td>
<td>1st Standard 1926 (300.0 mg) 2nd Standard 1936 (90.0 mg) 3rd Standard 1949</td>
</tr>
<tr>
<td>Hyaluronidase, bovine</td>
<td>Approx. 200 IU per tablet</td>
<td>-</td>
<td>Ampoules containing 10 tablets of approximately 20 mg of dried bovine testicular hyaluronidase diluted with lactose (10 IU/mg)</td>
<td>1st Standard 1955</td>
</tr>
<tr>
<td>Vitamin D</td>
<td>-</td>
<td>1.0</td>
<td>Bottles containing approximately 6 g of a solution of vitamin D3 in vegetable oil (1000 IU per g)</td>
<td>1st Standard 1931 (0.1 mg) 2nd Standard 1949</td>
</tr>
</tbody>
</table>

1 The first standard for oxytocin and vasopressin, for bioassay, was established in 1925, the second in 1942 and the third in 1957. This combined standard was discontinued in 1978, when a separate standard for oxytocin, for bioassay, was established. Since the unitage of this standard was based on the oxytocin unitage of the combined standard, it was called the 4th Standard.

2 The International Nonproprietary Name of vitamin D3 is calciferol.
<table>
<thead>
<tr>
<th>Preparation</th>
<th>IU per ampoule</th>
<th>mg/IU (if relevant)</th>
<th>Form in which available</th>
<th>Years of establishment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTIBIOTICS</strong> (held in London)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleomycin complex A₅B₇</td>
<td>8 910</td>
<td>-</td>
<td>Ampoules containing 5 mg of bleomycin complex</td>
<td>1st Reference Preparation 1980</td>
</tr>
<tr>
<td>Cendicidin</td>
<td>0.0004766</td>
<td>0.00011944</td>
<td>Ampoules containing approximately 50 mg of cendicidin (2098 IU per mg)</td>
<td>1st Reference Preparation 1978</td>
</tr>
<tr>
<td>Cephalothin</td>
<td>0.0001087</td>
<td></td>
<td>Ampoules containing approximately 50 mg of cephalothin (920 IU per mg)</td>
<td>1st Reference Preparation 1967</td>
</tr>
<tr>
<td>Celastatin</td>
<td>-</td>
<td>0.0010661</td>
<td>Ampoules containing approximately 50 mg of sodium celastatin (938 IU per mg)</td>
<td>1st Reference Preparation 1965</td>
</tr>
<tr>
<td>Cilindamycin</td>
<td>-</td>
<td>0.0011967</td>
<td>Ampoules containing approximately 50 mg of cilindamycin hydrochloride (837 IU per mg)</td>
<td>1st Reference Preparation 1971</td>
</tr>
<tr>
<td>Colistin methane sulfonate¹</td>
<td>-</td>
<td>0.00007874</td>
<td>Ampoules containing approximately 75 mg of colistin methane sulfonate (1.700 IU per mg)</td>
<td>1st Reference Preparation 1966</td>
</tr>
<tr>
<td>Demethylchlortetacycline²</td>
<td>-</td>
<td>0.001</td>
<td>Ampoules containing approximately 80 mg of demethylchlortetacycline hydrochloride (1000 IU per mg)</td>
<td>1st Reference Preparation 1962</td>
</tr>
<tr>
<td>Doxycycline</td>
<td>0.0011494</td>
<td></td>
<td>Ampoules containing approximately 75 mg of doxycycline hydrochloride hemichloride hemihydrate (870 IU per mg)</td>
<td>1st Reference Preparation 1973</td>
</tr>
<tr>
<td>Gentamycin³</td>
<td>-</td>
<td>0.00156</td>
<td>Ampoules containing approximately 50 mg of gentamycin sulfate (641 IU per mg)</td>
<td>1st Reference Preparation 1968</td>
</tr>
<tr>
<td>Gramicidin</td>
<td>-</td>
<td>0.001</td>
<td>Ampoules containing approximately 55 mg of gramicidin (1000 IU per mg)</td>
<td>1st Reference Preparation 1966</td>
</tr>
<tr>
<td>Kanamycin</td>
<td>0.001232</td>
<td></td>
<td>Ampoules containing approximately 50 mg of kanamycin sulfate (822 IU per mg)</td>
<td>1st Reference Preparation 1959</td>
</tr>
<tr>
<td>Lincomycin</td>
<td>0.0011351</td>
<td></td>
<td>Ampoules containing approximately 50 mg of lincomycin hydrochloride (881 IU per mg)</td>
<td>1st Reference Preparation 1965</td>
</tr>
<tr>
<td>Lyneecycline</td>
<td>-</td>
<td>0.0010548</td>
<td>Ampoules containing approximately 100 mg of lyneecycline (948 IU per mg)</td>
<td>1st Reference Preparation 1968</td>
</tr>
<tr>
<td>Methacycline⁶</td>
<td>0.001082</td>
<td></td>
<td>Ampoules containing approximately 50 mg of methacycline hydrochloride (924 IU per mg)</td>
<td>1st Reference Preparation 1969</td>
</tr>
<tr>
<td>Minocycline</td>
<td>0.0011587</td>
<td></td>
<td>Ampoules containing approximately 75 mg of minocycline hydrochloride (863 IU per mg)</td>
<td>1st Reference Preparation 1975</td>
</tr>
<tr>
<td>Neomycin</td>
<td>-</td>
<td>0.0012903</td>
<td>Ampoules containing approximately 50 mg of neomycin sulfate (773 IU per mg)</td>
<td>1st Reference Preparation 1958</td>
</tr>
<tr>
<td>Neomycin B³</td>
<td>16 756</td>
<td>0.0001492</td>
<td>Ampoules containing approximately 25 mg of neomycin B sulfate (670 IU per mg)</td>
<td>1st Reference Preparation 1970</td>
</tr>
<tr>
<td>Paromomycin</td>
<td>-</td>
<td>0.001333</td>
<td>Ampoules containing approximately 75 mg of paromomycin sulfate (750 IU per mg)</td>
<td>1st Reference Preparation 1965</td>
</tr>
<tr>
<td>Procaine benzylpenicillin in oil with aluminium monostearate</td>
<td>-</td>
<td>-</td>
<td>Bottles containing approximately 10 ml of procaine benzylpenicillin in oil with aluminium monostearate, for injection</td>
<td>2nd Reference Preparation 1962</td>
</tr>
<tr>
<td>Rifamycin SV⁶</td>
<td>0.000127</td>
<td>0.001127</td>
<td>Ampoules containing approximately 100 mg of sodium rifamycin SV (887 IU per mg)</td>
<td>1st Reference Preparation 1967</td>
</tr>
<tr>
<td>Spectinomycin</td>
<td>-</td>
<td>0.00149</td>
<td>Ampoules containing approximately 75 mg of spectinomycin dihydrochloride pentahydrate (671 IU per mg)</td>
<td>1st Reference Preparation 1975</td>
</tr>
<tr>
<td>Spiramycin</td>
<td>-</td>
<td>0.0003125</td>
<td>Ampoules containing approximately 50 mg of spiramycin base (3200 IU per mg)</td>
<td>1st Reference Preparation 1962</td>
</tr>
</tbody>
</table>

¹ In some countries this antibiotic is known as “colistin sulphonate” or “colistimethate”.
² The International Nonproprietary Name of this substance has been changed to demethylchlortetacycline.
³ The International Nonproprietary Name of this substance has been changed to gentamicin.
⁴ The International Nonproprietary Name of this substance is metacycline.
⁵ The International Nonproprietary Name of this substance is fracycin.
⁶ The International Nonproprietary Name of this substance is rifamycin.
<table>
<thead>
<tr>
<th>Preparation</th>
<th>IU</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTIBIOTICS (held in London) (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobramycin</td>
<td>-</td>
<td>0.0010142</td>
<td>Ampoules containing approximately 80 mg of tobramycin base (986 IU per mg)</td>
<td>1st Reference Preparation 1980</td>
</tr>
<tr>
<td>Tricatylolideomycin(^1)</td>
<td>-</td>
<td>0.0012</td>
<td>Ampoules containing approximately 100 mg of tricatylolideomycin (973 IU per mg)</td>
<td>1st Reference Preparation 1962</td>
</tr>
<tr>
<td>Viomycin</td>
<td>-</td>
<td>0.0012285</td>
<td>Ampoules containing approximately 100 mg of viomycin sulfate (814 IU per mg)</td>
<td>1st Reference Preparation 1959 (0.00137 mg)</td>
</tr>
<tr>
<td><strong>ANTIBIOTICS (held in Weybridge, England)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nisin</td>
<td>-</td>
<td>0.001</td>
<td>Ampoules containing 85 mg of nisin (1000 IU per mg)</td>
<td>1st Reference Preparation 1969</td>
</tr>
<tr>
<td><strong>ANTIBODIES (held in Copenhagen)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-measles serum, human</td>
<td>10</td>
<td>-</td>
<td>Ampoules containing 93.8 mg of dried human serum</td>
<td>1st Reference Preparation 1964</td>
</tr>
<tr>
<td>Anti-rubella serum, human</td>
<td>1000</td>
<td>-</td>
<td>Ampoules containing 143.95 mg of freeze-dried human immunoglobulin</td>
<td>1st Reference Preparation 1966(^2) 2nd Reference Preparation 1970</td>
</tr>
<tr>
<td>Anti-staphylococcal P-V leucocidin serum, equine</td>
<td>150</td>
<td>-</td>
<td>Ampoules containing 55.5 mg of freeze-dried horse serum</td>
<td>1st Reference Preparation 1965</td>
</tr>
<tr>
<td>Anti-typhoid serum, equine</td>
<td>-</td>
<td>-</td>
<td>Ampoules containing 5 ml of dried hyperimmune horse serum</td>
<td>1st Reference Preparation 1952</td>
</tr>
<tr>
<td>Anti-yellow-fever serum, monkey</td>
<td>143</td>
<td>0.5</td>
<td>Ampoules containing approximately 71.5 mg of dried monkey serum</td>
<td>1st Reference Preparation 1962</td>
</tr>
<tr>
<td>Rheumatic arthritis serum, human</td>
<td>100</td>
<td>-</td>
<td>Ampoules containing 17.1 mg of freeze-dried pooled human serum</td>
<td>1st Reference Preparation 1970</td>
</tr>
<tr>
<td><strong>ANTIBODIES (held in Weybridge, England)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-Mycoplasma galliseptisium serum</td>
<td>1000</td>
<td>-</td>
<td>Ampoules containing 55.6 mg of freeze-dried chicken serum</td>
<td>1st Reference Preparation 1969</td>
</tr>
<tr>
<td>Anti-Newcastle-disease serum</td>
<td>320</td>
<td>-</td>
<td>Ampoules containing 55.5 mg of freeze-dried chicken serum</td>
<td>1st Reference Preparation 1966</td>
</tr>
<tr>
<td><strong>ANTIBODIES (held in London)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-thryoglobulin serum, human</td>
<td>1000</td>
<td>-</td>
<td>Ampoules containing approximately 44.3 mg of freeze-dried human autoimmune serum</td>
<td>1st Reference Preparation 1978</td>
</tr>
<tr>
<td><strong>ANTIGENS (held in Copenhagen)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rabies vaccine</td>
<td>10</td>
<td>-</td>
<td>Ampoules containing approximately 49.45 mg of freeze-dried rabies vaccine prepared in human diploid cells and inactivated with propiolactone</td>
<td>1st Reference Preparation 1960(^2) 3rd Reference Preparation 1978</td>
</tr>
<tr>
<td><strong>ANTIGENS (held in Weybridge, England)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anthrax spore vaccine</td>
<td>1.0</td>
<td>-</td>
<td>Ampoules containing a freeze-dried spore suspension of Bacillus anthracis strain 34 F2 (approximately 10³ culturable spores per ampoule)</td>
<td>1st Reference Preparation 1978</td>
</tr>
<tr>
<td><strong>BLOOD PRODUCTS AND RELATED SUBSTANCES (held in Copenhagen)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy-specific (^{1\text{st}}) glycoprotein</td>
<td>0.075</td>
<td>-</td>
<td>Ampoules containing 45.16 mg of freeze-dried purified serum from pregnant women</td>
<td>1st Reference Preparation 1982</td>
</tr>
<tr>
<td><strong>BLOOD PRODUCTS AND RELATED SUBSTANCES (held in London)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ancrod</td>
<td>55</td>
<td>-</td>
<td>Ampoules containing 16.90 mg of purified ancrod in lactose and human serum albumin</td>
<td>1st Reference Preparation 1976</td>
</tr>
<tr>
<td>Anti-D immunoglobulin, human</td>
<td>300</td>
<td>-</td>
<td>Ampoules containing 14.76 mg of human serum</td>
<td>1st Reference Preparation 1976</td>
</tr>
</tbody>
</table>

\(^1\) The International Nonproprietary Name of this substance has been changed to trioleandomycin.

\(^2\) No units were assigned to this preparation.
### LIST II. BIOLOGICAL REFERENCE PREPARATIONS (continued)

<table>
<thead>
<tr>
<th>Preparation</th>
<th>IU per ampoule</th>
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<th>Form in which available</th>
<th>Years of establishment (in brackets, weight of previous standard containing one IU)</th>
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</thead>
<tbody>
<tr>
<td><strong>BLOOD PRODUCTS AND RELATED SUBSTANCES (held in London)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antithrombin III, plasma</td>
<td>0.9</td>
<td></td>
<td>Ampoules containing the freeze-dried residue of 1 ml human plasma</td>
<td>1st Reference Preparation 1978</td>
</tr>
<tr>
<td>Carcinobistryptic antigen (CEA), human</td>
<td>100</td>
<td></td>
<td>Ampoules containing 2.26 mg of freeze-dried carcinoMbistryptic antigen</td>
<td>1st Reference Preparation 1975</td>
</tr>
<tr>
<td>Blood coagulation factor VIII:related activities in plasma</td>
<td>0.71</td>
<td></td>
<td>Ampoules containing the freeze-dried residue of 1 ml human plasma</td>
<td>1st Reference Preparation 1982</td>
</tr>
<tr>
<td>Human serum proteins</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human serum complement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human serum albumin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human serum IgG, IgA, and IgM</td>
<td>100 (of each)</td>
<td></td>
<td>Ampoules containing approximately 81 mg of the freeze-dried residue from diluted pooled human serum (100 IU IgG, 100 IU IgA, and 100 IU IgM per ampoule)</td>
<td>1st Reference Preparation 1970</td>
</tr>
<tr>
<td>Plasmin, human</td>
<td>10</td>
<td></td>
<td>Ampoules containing approximately 1.0 ml of a solution of partially purified plasmin in 50% glycerol</td>
<td>1st Reference Preparation 1976, 2nd Reference Preparation 1980</td>
</tr>
<tr>
<td>Thromboplastin, bovine; combined</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thromboplastin, human, combined</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thromboplastin, rabbit, plain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urokinase, human</td>
<td>4 800</td>
<td></td>
<td>Ampoules containing approximately 1.4 mg of partially purified freeze-dried urokinase from human urine, with 5 mg lactose</td>
<td>1st Reference Preparation 1978</td>
</tr>
<tr>
<td><strong>BLOOD PRODUCTS AND RELATED SUBSTANCES (held in Amsterdam)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-nuclear-factor serum (homogeneous), human</td>
<td>100</td>
<td>0.186</td>
<td>Ampoules containing approximately 19 mg of the freeze-dried residue of 0.2 ml of pooled human serum (18.6 mg ± 5.83)</td>
<td>1st Reference Preparation 1970</td>
</tr>
<tr>
<td>Hepatitis A immunoglobulin</td>
<td>100</td>
<td></td>
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<td>Human serum complement components Clq, C4, C5, factor B and whole functional complement CH50</td>
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1 Serve from the same batch of material as this international reference preparation is available from the Director, National Institute for Biological Standards and Control, Hampstead, London N3 6BB, England.
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<td>(LH)</td>
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ANNEX 5

INFANT AND YOUNG CHILD NUTRITION (PROGRESS AND EVALUATION REPORT; STATUS OF IMPLEMENTATION OF THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES)¹

Report by the Director-General

[AC37/6 - 23 March 1984]

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<td>Conclusion</td>
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See resolution WHA37.30.
INTRODUCTION

1. The activities described in this report are themselves only part of a larger programme of family health promotion as a component of primary health care. This overall programme area, which focuses on maternal and child health needs and family planning, including improved infant and young child feeding and the betterment of the health and nutrition of the family as a whole, has been designated an essential element of the strategy for health for all by the year 2000.

2. The term malnutrition covers a number of diseases, each with its own etiology relating to a specific nutrient or combination of nutrients. These diseases are a result of a metabolic imbalance, at the cellular level, between the supply of nutrients and energy and the body's need for them to ensure maintenance, function and growth. Malnutrition can be prevented by modifying, or removing altogether, factors that interfere with the normal flow of nutrients and energy to the cell at any of several stages, from food availability through absorption to final use by the body. It can also be cured, by adding to nutrient and energy supply (in deficiency states), or by reducing them (in cases of excess). Malnutrition can be produced experimentally, in animal models, and has clearly defined anthropometric, clinical and biochemical features.

3. The body's first response to nutrient and energy imbalance is adaptation. In cases of severe or prolonged stress, however, adaptation fails. It is at this stage that malnutrition becomes a medical problem, both by itself and in conjunction with other closely related illnesses.

4. There are a number of health and non-health factors that interfere with nutrient and energy flow in conditions of malnourishment. While food availability is undeniably a major concern, malnutrition is neither synonymous with nor an inevitable consequence of consumption of too little food. A key factor is the individual's ability to obtain full benefit from the food that is consumed, whatever the amount. Infection and disease impair this process; when food is scarce the increased need for energy aggravates the effects of malnutrition, and the situation may deteriorate further with loss of appetite in the sick individual. The undernourished are more susceptible to infection and disease, and thus a vicious circle is formed.

5. The prevention, detection and management of malnutrition depend not only on identifying which factors are responsible for the condition, but also on discovering with some degree of precision which population groups are malnourished, their geographical location and associated epidemiological factors. This is the only suitable basis on which sound nutrition strategies can be planned.

6. Although malnutrition due to excess is a serious threat to health and survival at older ages, the most severe and widespread forms of malnutrition in the world today are related to one or more of five deficiencies: protein, energy, iron, iodine and vitamin A. WHO has assigned the highest priority within its overall programme of nutrition in primary health care to supporting efforts by countries to reduce and eliminate them. Its approach to the problem includes:

   (1) promoting awareness at all levels of the prevalence of these deficiencies and their effects on the health of vulnerable groups;

   (2) developing improved methods of prevention, detection and control, and guidelines for their application; and

   (3) providing technical and other support to countries for strengthening their capabilities in nutrition, including problem definition and programme formulation and implementation, in collaboration with UNICEF, UNFPA, FAO and other bodies and organizations of the United Nations system, as well as with the support of various bilateral development agencies.

7. It is on the basis of this understanding of malnutrition, and WHO's response to it, that Part I of this report provides up-to-date information on selected global and regional nutritional status trends among women, infants and young children; Part II highlights some of the practical steps taken since 1982, by WHO and its Member States, to develop policies and implement action programmes for dealing with the multiple factors that interfere with the flow of nutrients and energy needed to ensure adequate maintenance, function and growth among infants and young children.
Part I

UPDATED INFORMATION ON SELECTED GLOBAL AND REGIONAL TRENDS IN NUTRITIONAL STATUS

8. Based on the initial results of numerous recent national surveillance and monitoring activities, information was presented to the Thirty-sixth World Health Assembly in May 1983 with regard inter alia to acute malnutrition, low birth weight, goitre, vitamin A deficiency, and anaemia, for developing countries in Africa, the Americas, and Asia. It was intended that the crude data reported at this time should contribute to the establishment of a baseline for monitoring change in nutritional status and aid the detection of areas where special action and support are called for. The 1983 report concluded that additional data collected on a longitudinal basis are required so that national strategies can be appropriately directed to improve the nutritional status of those groups most in need.

9. The information that follows on the incidence of low birth weight, trends in the prevalence of protein-energy malnutrition among children under five years of age, and the prevalence of nutritional anaemia, iodine deficiency, and vitamin A deficiency, is part of a continuing effort by WHO to compile and analyse data on major aspects of the regional and global nutritional situation. It is hoped that this information will serve the Organization and its Member States in their efforts to assess needs, formulate appropriate policies, and implement the necessary nutrition action programmes, through primary health care, for meeting them.

INCIDENCE OF LOW BIRTH WEIGHT BY GEOGRAPHICAL REGION

10. Low birth weight (LBW) is the most significant indicator of the risk to survival and healthy growth and development, and is thus an important guide to the level of care needed by the individual infant. Because birth weight is conditioned by the health and nutritional status of the mother, the proportion of infants with LBW also serves as an index of the overall health status of mothers and communities. In particular, it reflects the health and nutritional deficiencies of pregnant women, the too close spacing of births, excessive work load during pregnancy, and inadequate prenatal care. LBW is thus an indicator of health status and quality of life that continues to merit particular attention, especially where action to reduce infant morbidity and mortality is concerned. This is borne out by the Health Assembly's decision to include it among the indicators for monitoring progress towards health for all.

11. There are practical problems associated with the use of this indicator. For example, while most infants are weighed at birth in developed countries, a recent survey showed that only about one-third of births in the developing world take place in institutions (e.g., hospitals, maternity homes) where routine weighing is likely to occur. In some countries the proportion is lower than one-fifth of all births. And even in those cases where records of birth weights are kept at the institutional level they are rarely collated at the national level. When a majority of births take place outside health institutions the statistics on LBW based on deliveries at institutions may be considerably biased, with no certainty as to the direction and magnitude of the bias.

---

1 Document A36/7, Part I.

2 All references in this context to geographical regions are made in accordance with standard United Nations usage. See Demographic indicators of countries: estimates and projections as assessed in 1980, New York, United Nations, 1982 (ST/ESA/SER.A/82).


4 WHO estimate based on data from various sources.
12. The last global survey of the incidence of LBW (weight less than 2500 g)\(^1\) prepared by WHO was based on information available up to 1979.\(^2\) Table 1 below brings this survey up to date, by geographical region, with old and new information expressed in terms of both estimated numbers of births and the percentage of infants with LBW. In order to facilitate comparisons with the earlier survey, the estimated percentage of infants with LBW for 1979 has also been included (see also Fig. 1).

13. The latest investigation, carried out at the end of 1983, yielded new information on 90 countries; for 18 of them (including 14 developing countries) no information had previously been available. The estimated incidence of LBW, globally and in most regions, is lower for 1982 than for 1979 — whether as a result of real improvements in the situation or of increased availability and reliability of information it is hard to say. Previous estimates were altered only when sample size and representativeness, as well as the overall reliability of new findings, appeared to justify change. Where new data failed to show a clear tendency, previous estimates have been left unaltered.

Global estimates and trends

14. The total number of live births, approximately 85% of which occur in developing countries, increased from 122.3 million in 1979 to 127.4 million in 1982,\(^3\) whereas the total number of LBW infants for the same years was estimated to have decreased from 20.6 million to 20.3 million. Thus the global estimated proportion of infants with LBW decreased from 17% in 1979 to 16% in 1982. For developing countries only, the proportion of infants with LBW decreased during the same period from 18% to 17%, with considerable variations both between and within geographical regions (from 31% in Middle South Asia and 19% in Asia as a whole, to 14% in Africa, 10% in Latin America, and 7% each in Europe and Northern America).

Estimates and trends by region

15. Africa. The proportion of infants with LBW for Africa as a whole decreased from 15% to 14%, the changes in Northern Africa from 13% to 10% and in Southern Africa from 15% to 12% being the most important improvements for this continent. There is no evidence of substantial change for most of Western and Eastern Africa, while the paucity of new information for countries in Middle Africa resulted in only slight change, and this with respect to one country only.

16. Northern America. There were only slight improvements in the already low rates for both Canada and the United States of America, but not significant enough to warrant alteration of the 1979 estimates.

17. Latin America. The overall proportion of infants with LBW decreased from 11% to 10%, and there is evidence, based on national data, of real improvements in some countries, for example Cuba, Panama, Uruguay and Venezuela.

18. Asia. Although the overall incidence of LBW has decreased from 20% to 19%, the situation in the most populous countries (Bangladesh, India and Pakistan) appears to remain unchanged. The rates there — 30% to 50% — are among the highest in the world. The low rates in some countries of Western South Asia, for which no information had previously been available, reduce the estimate to 7% for this sub-region. The most notable changes in Eastern South Asia occurred in Singapore and Thailand. The proportion of LBW infants in East Asia remained unchanged at the very low rate of 6%.

19. Europe. Overall incidence in this region decreased from 8% to 7%, although once again this may be partially attributable to increased availability and reliability of information,

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\(^{1}\) Because most reports do not specify gestational age at birth, the 2500 g limit includes both full-term or pre-term infants who are truly malnourished, and pre-term infants of appropriate weight for gestational age. A number of studies indicate that pre-term births in developing countries account for no more than 25% of the total number of infants with low birth weight.


\(^{3}\) United Nations Population Division estimate.

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Note: All calculations were done before rounding.
Source: Live births - United Nations Population Division; proportion of low birth weight - WHO, based on information from various sources.
FIG. 1
PREVALENCE OF INFANTS WITH LOW BIRTH WEIGHT, BY COUNTRY, 1982
particularly with regard to one large country. Very little change was registered in countries where rates were already low (below 5%) in 1979, nor was there any evidence of significant change in Eastern Europe.

20. In conclusion, birth weight as a measure of the outcome of the period of most rapid growth and development of the human lifespan — the intrauterine period — is the most significant indicator of an infant’s chances of survival and healthy growth and development. It is also a useful gauge of overall health and socioeconomic development. Factors associated with the outcome of pregnancy in terms of birth weight include: gestational age; maternal nutritional status, age, size, and weight; inter-pregnancy interval; parity; socioeconomic status; education; smoking; and maternal morbidity during pregnancy.

21. As with many health problems reduction in LBW can be expected to accompany balanced socioeconomic development, particularly the extension of appropriate health care to high risk groups. Possibilities for immediate intervention to reduce the incidence of LBW are nonetheless available to the health sector, for example, the prevention and management of diseases during pregnancy and the promotion of appropriate dietary intake as a function of energy output combined with a reduction in work load. However, they are valid only to the extent that two main limitations can be overcome: the difficulty of reaching and involving at-risk populations, and the lack of appropriate technology for effective application of scientific knowledge under prevailing conditions.

22. The primary health care approach offers the best opportunity for extending to underserved rural and periurban populations the essential support system that is necessary to reduce the problem of LBW and to cope with its consequences. 1

COMPARATIVE TRENDS IN THE PREVALENCE OF PROTEIN-ENERGY MALNUTRITION AMONG CHILDREN UNDER FIVE YEARS OF AGE, BY GEOGRAPHICAL REGION, 1963-1983

23. A target weight of at least 2500 g for newborn infants and the attainment of adequate growth as measured by weight-for-age together constitute one of the 12 points included in the short list of indicators for global monitoring and evaluation of the Global Strategy for Health for All by the Year 2000. 2 Progress towards the achievement of these and other targets forms part of the subject of reporting and impact assessment by WHO and its Member States at national, regional, and global levels. Of considerable interest in this context is information on recent trends against which present and future trends can be assessed.

24. Table 2 below compares the estimated percentages and crude numbers of malnourished children under the age of five in developing countries, by region, for two periods, 1963-1973 and 1973-1983. Trends in the prevalence of protein-energy malnutrition (PEM) were estimated by comparing the results of various surveys conducted during the first period with similar surveys conducted during the second. There were a number of drawbacks including the fact that the surveys in question were carried out at different times during the two periods. Intervals between surveys were irregular and the limited country data, as well as variations among sample and survey sites, were challenges to estimating trends accurately.

25. The total number of cases measured for the earlier decade was relatively small — some 52,000 children in 29 countries. Information for the second decade was somewhat improved with 93,000 children measured in 43 countries. However, the same countries were not necessarily surveyed during both time frames, and most of the more reliable national sample surveys were conducted during the second decade. It is clear, therefore, that only a gross estimate of trends can be made on this basis.

1 A consultation sponsored by WHO in Geneva in May 1982 prepared guidelines for the feeding of LBW and pre-term infants under different socioeconomic conditions. The guidelines included such aspects of the problem as the physiological characteristics of infants with LBW; their nutritional requirements; available feeding methods and technologies and the advantages of breast milk; support to the mother of an infant with LBW; and milk banking and the need for the development of appropriate technologies for this purpose in developing countries.

TABLE 2. ESTIMATED PROTEIN-ENERGY MALNUTRITION (PEM) PREVALENCE, BY REGION, DETERMINED AS A PERCENTAGE OF CHILDREN WITH LOW WEIGHT-FOR-AGEa

<table>
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<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>0</td>
<td>18.6%</td>
<td>15.1%</td>
</tr>
<tr>
<td>1</td>
<td>40.5%</td>
<td>35.2%</td>
</tr>
<tr>
<td>2</td>
<td>36.7%</td>
<td>29.9%</td>
</tr>
<tr>
<td>3</td>
<td>31.4%</td>
<td>23.9%</td>
</tr>
<tr>
<td>4</td>
<td>28.1%</td>
<td>23.8%</td>
</tr>
<tr>
<td>Average</td>
<td>31.1%</td>
<td>25.6%</td>
</tr>
<tr>
<td>Crude number malnourished: 19.9 million</td>
<td>Crude number malnourished: 21.9 million</td>
<td></td>
</tr>
</tbody>
</table>

Africa

5576 children were measured in surveys of Burundi, Ivory Coast, Libyan Arab Jamahiriya, Malawi, Sudan, Togo, Tunisia, Uganda, and United Republic of Tanzania:

45 084 children were measured in surveys of Cameroon,* Egypt, Ethiopia, Ghana, Guinea-Bissau,* Lesotho, Liberia,* Madagascar, Nigeria, Sierra Leone,* Togo,* Tunisia,* Uganda, Upper Volta, and Zaire:

Age: 0 malnourished: 15.1%
Age: 1 malnourished: 35.2%
Age: 2 malnourished: 29.9%
Age: 3 malnourished: 23.9%
Age: 4 malnourished: 23.8%
Average: 25.6%
Crude number malnourished: 21.9 million

The Americasb

8440 children were measured in surveys of Belize, Bolivia, Brazil, Colombia,* Costa Rica,* Dominica, Dominican Republic,* Haiti,* Honduras, Jamaica,* and Nicaragua:

20 720 children were measured in surveys of Barbados,* Colombia,* Costa Rica,* El Salvador, Guatemala, Guyana,* Haiti, Honduras, Jamaica, Nicaragua, Panama, Saint Vincent and the Grenadines, Trinidad and Tobago, and Turks and Caicos Islands:

Age: 0 malnourished: 15.0%
Age: 1 malnourished: 21.9%
Age: 2 malnourished: 21.3%
Age: 3 malnourished: 17.9%
Age: 4 malnourished: 17.7%
Average: 17.7%
Crude number malnourished: 8.6 million

AsiaC

37 050 children were measured in surveys of Democratic Yemen, India,* Islamic Republic of Iran, Philippines,* and Yemen:

25 673 children were measured in surveys of Bangladesh,* Burma, Democratic Yemen, India, Indonesia, Islamic Republic of Iran, Jordan, Malaysia, Nepal,* Sri Lanka,* and Yemen:

Age: 0 malnourished: 24.9%
Age: 1 malnourished: 60.0%
Age: 2 malnourished: 61.4%
Age: 3 malnourished: 60.2%
Age: 4 malnourished: 62.5%
Average: 54.0%
Crude number malnourished: 114.6 million
TABLE 2. ESTIMATED PROTEIN-ENERGY MALNUTRITION (PEM) PREVALENCE, BY REGION, DETERMINED AS A PERCENTAGE OF CHILDREN WITH LOW WEIGHT-FOR-AGE (continued)

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Oceaniad</td>
<td></td>
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</tr>
<tr>
<td>787 children were measured in a survey of Solomon Islands:</td>
<td>1519 children were measured in surveys of Kiribati, Papua New Guinea, and Samoa:</td>
<td></td>
</tr>
<tr>
<td>Age: 0 malnourished: 15.6% Age: 0 malnourished: 3.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 26.8% 1 21.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 20.3% 2 17.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 23.4% 3 5.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 24.0% 4 9.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average 22.0% Average 11.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude number malnourished: 0.5 million Crude number malnourished: 0.3 million</td>
<td></td>
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</tr>
</tbody>
</table>

Estimated total number and percentage of malnourished children under five years of age in developing countries in the above regions:

1963-1973: 125.9 million (42.7%) 1973-1983: 145.4 million (42.3%)

Note: Population figures for children under five were taken from Demographic indicators of countries: estimates and projections as assessed in 1980, New York, United Nations, 1982 (ST/ESA/SER.A/82).

a Defined as less than two standard deviations below the median of the United States National Center for Health Statistics reference population.

b Excluding Argentina, Chile, Paraguay, and all of North America.

c Excluding China, Democratic People's Republic of Korea, Hong Kong, Japan, Mongolia, Republic of Korea, and the USSR; weighted for India.

d Excluding Australia and New Zealand.

* National surveys.
26. Because of its recurrent use in epidemiological surveys for determining the prevalence of PEM, weight-for-age was employed as the comparison indicator. Prior to the mid-1970s few surveys used weight-for-height (for thinness or wasting) or height-for-age (for shortness or stunting) as indicators of malnutrition, although it is now recognized that weight-for-age is a composite of these two more specific indicators.

27. A recent global comparison of data concerning malnutrition 1 showed that low weight-for-age was, for the most part, an approximate reflection of the proportion of children with low height-for-age, especially in the age-groups above two years. This suggests that stunting is the dominant form of malnutrition, and that a larger proportion of the low weight-for-age children is likely to be stunted than wasted, contrary to the image of malnutrition that is projected via the popular media. However, this tendency does not preclude the possibility that changes in the percentage of children with low weight-for-age may result from changes in either weight-for-height or height-for-age, or both. 2 The geographical distribution of low weight-for-height or acute malnutrition in one-year-old children is shown in Fig. 2.

28. In attempting to measure PEM prevalence, it is not possible to say with certainty that improvements detected (expressed as a drop in the percentage of children with low weight-for-age) are a result of an overall decrease in the number of children suffering from wasting, a global increase in the height of children, or even a combination of the two factors. The converse would also be true if an increase in the percentage of malnourished children, according to weight-for-age, were to be detected. Even if the percentage of low weight-for-age children remained approximately the same over a given period, it would be equally possible for wasting to have increased while stunting decreased, or vice versa. Despite its obvious drawbacks, weight-for-age was still the most consistently used indicator of malnutrition applied to the survey data reviewed from the last 20 years. Therefore, in the present context, the terms "malnutrition" and "malnourished" refer exclusively to children with low weight-for-age.

29. In determining trends in malnutrition it is essential, besides using the same indicator(s) when comparing data, to use the same limit to distinguish malnourished from non-malnourished children. Also, since there is considerable fluctuation in the percentage of malnourished children at different ages, it is necessary to break down the data into one-year age-groups.

30. When data from the Americas (excluding Argentina, Chile, Paraguay, and all of North America) were averaged by age-group, each group showed a trend towards improvement; that is, proportionately fewer children were found to be malnourished, on the basis of low weight-for-age, between 1973 and 1983 than between 1963 and 1973. The same trend was detected for Africa (see Table 2). However, while there may have been some improvement in the Americas in terms of a decrease in the absolute numbers of malnourished children, in Africa absolute numbers remained fairly constant during this time span as a result of an overall increase in population.

31. The country sample size is too small to make a general observation about PEM trends in Oceania (excluding Australia and New Zealand) although, according to the surveys analysed, PEM may well be decreasing in this region. When data for Asia (excluding China, Democratic People's Republic of Korea, Hong Kong, Japan, Mongolia, Republic of Korea, and the USSR, and using weighted data for India) were averaged, the trend of improvement in PEM prevalence did not seem to continue. In absolute numbers, the situation appears to have worsened.

32. In conclusion, the problem of malnutrition among children appears not to have worsened among developing countries in the regions reviewed when expressed in percentage terms based on weight-for-age. However, the increase in population during the last 20 years appears to have resulted in an increased absolute number of malnourished children under the age of five than was generally the case 10 years ago. These overall findings do not, of course, rule out examples of countries where a significant reduction in both percentage and absolute numbers of malnourished children has been registered, as in the case, for example, of Bangladesh, Colombia, and Costa Rica.

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2 See Table 1 (Estimated prevalence and number of cases of nutritional deficiency in developing countries, by region) in document A36/7, p. 6.
FIG. 2
PREVALENCE OF ACUTE MALNUTRITION (WASTING) IN CHILDREN AT ONE YEAR OF AGE, BY COUNTRY OF ORIGIN OF THE REPORT

[Map showing prevalence of acute malnutrition (wasting) in children at one year of age, by country of origin of the report.]
33. It is interesting to note the similarity between the present global estimate and the first attempt by WHO in 1974 to use indicators to give a global picture of protein-energy malnutrition. Although the earlier study used a variety of indicators and age-groups, it was still estimated that there were not more than 100 million malnourished children on the basis of data collected between 1963 and 1973, including countries in temperate South America. In the future more accurate estimates of trends that shed more light on types of malnutrition may be possible through the increased use of the more specific indicators, weight-for-height and height-for-age. At this stage, however, even information based on weight-for-age alone provides a reasonably clear picture of the gravity of the global situation; the degree of change registered over time; and the magnitude of the problem to be faced if real progress in the prevention and control of malnutrition among under-fives is to be made.

SPECIFIC NUTRITIONAL DEFICIENCIES

34. While there are signs that the global situation is improving somewhat in relative terms, the absolute numbers suffering from nutritional anaemias, especially iron deficiency anaemia, and endemic goitre and vitamin A deficiency strongly suggest the need to redouble preventive and curative efforts at all levels. This is all the more compelling a conclusion when one considers that relatively low-cost technology has already been developed, and successfully applied at the national level, for controlling goitre and vitamin A deficiency. Dealing with iron deficiency anaemia is more difficult; and yet there is a degree of mild encouragement in the contribution health systems organized according to the principles of primary health care can make to increase the effectiveness of anaemia control programmes.

Prevalence of nutritional anaemia in women in developing countries

35. Nutritional anaemia affects all age-groups and both sexes, including pre-school children, who are extremely vulnerable. The problem is most acute among women, where it contributes significantly to maternal morbidity and mortality. Nutritional anaemia is estimated to affect nearly two-thirds of pregnant and one-half of non-pregnant women in developing countries.

36. A survey of available information up to 1978 on the prevalence of anaemia in women in developing countries was reported on in the World Health Statistics Quarterly. Updating of this information, undertaken in late 1983, has tended merely to confirm the status quo. Thus, in general, the present overall prevalence of nutritional anaemia among women of reproductive age in developing countries is unchanged from that reported for 1978: fully half of these women - 290 million of an estimated total of 580 million women in 1982 - are suffering from anaemia caused by a deficiency of one or more essential nutrients (chiefly iron, plus folate during pregnancy).

37. This is the situation, region by region, in the developing world in 1984:

- in Africa, 63% of 19.1 million pregnant and 40% of 94.4 million non-pregnant women are anaemic;
- in Asia, 65% of 44.3 million pregnant and 57% of 325.1 million non-pregnant women (excluding China) are anaemic;
- in the Americas, 30% of 10.3 million pregnant and 15% of 83.2 million non-pregnant women are anaemic.

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2 Haemoglobin concentrations below which anaemia is likely to be present at sea level among adult females, non-pregnant (12 g/100 ml) and pregnant (11 g/100 ml) (see WHO Technical Report Series, No. 503, 1972).
4 WHO estimate based on United Nations demographic data (excluding China).
38. Generally speaking, progress achieved in the control of anaemia has been far less satisfactory than in the case, for example, of either vitamin A deficiency or endemic goitre. There are several reasons for this, including the facts that (1) although there is sufficient iron in most diets, the actual absorption rate is low; (2) the tools thus far developed for control purposes, as well as measures to change diets, are inadequate; and (3) with regard to the distribution of iron tablets, it is difficult to reach vulnerable groups and obtain their cooperation in prevention programmes, the latter particularly in view of the long duration of treatment and the frequency of side effects. Although many countries have undertaken to control iron deficiency anaemia through the mass distribution of iron tablets, very few of these programmes appear to have succeeded.¹

39. Recent field trials in the iron fortification of food in Guatemala, India and Thailand, while not yet conclusive, appear to point the way to an effective alternative approach to iron supplementation of the diet of the general population. Anaemia is not merely a question of the lack of iron in the diet, however, although this too may be a problem. Efforts must also be made to remove impediments to iron absorption that occur in the body as a result of overall dietary imbalances, as well as to overcome the effects of iron losses owing, for example, to parasites and too frequent pregnancies.

40. Considerably more research and development are necessary if iron supplementation and other initiatives are to have an appreciable effect on the control of anaemia. The development of long-lasting iron preparations, for oral consumption, free of side effects, would constitute a major achievement in this field, and research and development activities are under way within the pharmaceutical industry. Similarly, the development of a simple process for assessing critical haemoglobin levels, particularly one suitable for widespread use by various categories of health workers in health systems based on the primary health care approach, would greatly facilitate the screening of anaemia patients. Present methods are either unreliable or too complex and expensive for widespread use, particularly in developing countries.²

Iodine deficiency diseases

41. Iodine deficiency is the major factor responsible for endemic goitre, which is epidemiologically associated with cretinism, deaf-mutism, and mental deficiency. The prevalence and severity of goitre among women is of particular concern because of the danger of cretinism in their offspring.

42. The occurrence and worldwide distribution of endemic goitre is well documented, and affects more than 200 million people.³ It no longer constitutes a problem of public health significance in North and Central America and Europe, but it does in parts of South America, especially in Bolivia, Ecuador and Peru. Endemic goitre is still a severe and widespread problem in Africa, and in a number of countries in Asia and the Pacific.

¹ The problems associated with the mass distribution of iron tablets, as well as the potential impact on anaemia control of health systems that are organized according to the principles of primary health care, were among topics discussed at a symposium organized by WHO within the context of the Fourth Asian Congress on Nutrition held in Bangkok in November 1983.

² One such technique for assessing critical haemoglobin levels was developed by the PAHO/WHO Caribbean Food and Nutrition Institute, and field tested by community health workers in one country of the Region of the Americas. A bilateral development agency has expressed interest in supporting the mass industrial production of the technique's measuring device.

43. Proven techniques, both simple and cheap, are available to control iodine deficiency. They do not involve sophisticated technology and can be used everywhere in the world. However modest in scope and cost programmes capable of controlling endemic goitre may be, their successful implementation is only in part a medical problem. Another important dimension is the political will to improve the health status of the entire population, and to overcome various geographic, economic, and administrative obstacles concerning the choice and delivery of practical vehicles for iodine supplementation.

44. The regional committees have recognized the need for WHO to actively promote control programmes in countries where iodine deficiency is still a threat to public health. Such programmes are being undertaken by governments in the regions concerned, with the support of WHO and UNICEF, including their Joint Nutrition Support Programme in South America (see paragraphs 52-55).

Vitamin A deficiency

45. Xerophthalmia, the eye disease that is due to vitamin A deficiency, can lead in its severe forms to nutritional blindness through softening of the cornea (keratomalacia) and to destruction of the eye. The mortality rate among the nearly one million pre-school children who it is estimated become blind every year as a result of xerophthalmia is very high (60% to 70%). Even mild cases of xerophthalmia contribute to increased morbidity and mortality in young children. The disease is observed in a number of developing countries in Africa, Asia, and the Western Pacific, with isolated foci in the Caribbean and Latin America.

46. As with endemic goitre, simple, relatively inexpensive techniques exist to control vitamin A deficiency, in particular through periodic mass distribution of large doses of vitamin A and the fortification of certain foods. The environmental and organizational obstacles to the delivery of the vitamin A supplement are also similar, however, and no less formidable in practical terms.

47. Among the countries with xerophthalmia control programmes, recent information from three of the more populous - Bangladesh, India and Indonesia - provide encouraging examples of what can be achieved through concentrated control programmes. Recent data from Bangladesh show that the vitamin A distribution programme has reached 80% of the at-risk population. The Indian National Institute of Nutrition reports that the national distribution programme has significantly reduced prevalence of xerophthalmia and nutritional blindness among pre-school children. Similar prevalence trends have recently been observed in Indonesia in Aceh, Bali and Central Java provinces and the island of Lombok, where the national programme is closely supervised. On the other hand, the prevalence of xerophthalmia appears to have remained stable, or even to have increased, in those provinces that are not covered by the programme.

48. Work is also under way in Indonesia to test the feasibility of fortifying monosodium glutamate with retinol palmitate in order to provide an additional, readily available and consumable source of vitamin A in the household diet. A programme of sugar fortification with vitamin A begun in a number of countries of Central America in 1975 continues with a high degree of success.
Part II
INFANT AND YOUNG CHILD FEEDING

49. This represents the third in a series of progress reports prepared in accordance with resolution WHA33.32, which requested the Director-General to submit to the Health Assembly, first in 1981, and thereafter in even-numbered years, a report on the steps taken by WHO to promote breast-feeding and to improve infant and young child feeding.

50. The five-theme framework that has been used in past progress reports serves 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.

Information with respect to the appropriate marketing and distribution of breast-milk substitutes is presented in accordance with Article 11.7 of the International Code of Marketing of Breast-milk Substitutes, which provides for a report to the Health Assembly in even-numbered years on the status of its implementation.

51. Information on the status of implementation of the International Code is limited to new developments occurring since the preparation of the relevant portion of a report by the Director-General to the Executive Board in January 1983 and to the Thirty-sixth World Health Assembly in May 1983 respectively. It should, therefore, be read in the light of that report, as well as of section VI of the progress report submitted to the Thirty-fifth World Health Assembly. Together, the three reports provide an overall view of the steps that have been taken by some 130 countries and territories, in all WHO regions, to give effect to the International Code since its adoption in May 1981.

Joint WHO/UNICEF Nutrition Support Programme

52. Since the last progress report presented in May 1982, a pledge of US$ 85.3 million by the Government of Italy has permitted WHO and UNICEF to launch the Joint Nutrition Support Programme (JNSP), which is a five-year plan for increased support to national efforts to develop nutrition in primary health care programmes in a number of developing countries.

53. With primary health care as its central focus, the JNSP's main objectives are a reduction of infant morbidity and mortality, the promotion of child growth and development, and the improvement of maternal nutrition. Efforts are being made to attain these objectives through strengthening national problem-solving capacities, increasing collaboration between all relevant national sectors and international agencies, giving priority to women and children in low-income families, and ensuring more widespread dissemination of information. The programme's built-in evaluation mechanism is designed both to allow for a flexible approach to modifying current project activities and to simplify assessment of their final impact.

1 Submitted to the Thirty-fourth World Health Assembly in May 1981 (document A34/7) and the Thirty-fifth World Health Assembly in May 1982 (document WHA35/1982/REC/1, Annex 5).
3 Documents EB71/21 and A36/7, Part III, respectively.
4 Document WHA35/1982/REC/1, Annex 5, p. 84.
54. National JNSP-supported projects are under way, or have been planned, in Angola, Burma, Dominica, Ethiopia, Haiti, Mali, Mozambique, Nepal, Nicaragua, Niger, Peru, Saint Vincent and the Grenadines, Somalia, Sudan, and the United Republic of Tanzania; and, for the control of endemic goitre, in Bolivia, Ecuador and Peru. All of these projects are integral parts of the national development, including health and nutrition programmes, of the countries concerned. While project activities fall primarily within the health sector, other related sectors, for example agriculture, education, and community development, are also participating.

55. In the context of the present report, JNSP activities will be highlighted, as appropriate, under the relevant headings.

ENCOURAGEMENT AND SUPPORT OF BREAST-FEEDING

Workshops

56. WHO continues to support governments by sponsoring and participating in national, regional and interregional workshops designed to protect breast-feeding where it is the norm, and promote the practice where it is at risk of declining. Workshops have proved to be useful tools in helping to draw the attention of policy-makers to the importance of breast-feeding in terms of its direct contribution to the successful implementation of food and nutrition policies, the improvement of maternal and child health, and the enhancement of family planning objectives. Workshops have proved to be equally important in increasing awareness among policy-makers of the importance of accurate, up-to-date information on feeding practices as a prerequisite for sound policy formulation in these fields. They also provide those who are most directly involved — health personnel at all levels of primary health care including, in particular, midwives and nurses, as well as nutritionists, paediatricians, obstetricians, health planners and administrators, sociologists, health education specialists, and legislators — with valuable opportunities to exchange views, learn from each other's experiences and, as appropriate, undergo training in infant-feeding surveillance techniques. These various aspects of the role workshops play in encouraging and supporting breast-feeding are discussed further below.

Cooperation with various interested groups

57. Because of the important contribution to the promotion of breast-feeding of nongovernmental organizations, including consumer groups; bilateral development agencies; and other organizations of the United Nations system, WHO collaborates with these bodies wherever possible. For example, an international conference on community-based support for infant and young child feeding was co-sponsored by WHO, UNICEF and La Leche League International (Kingston, November 1982) to discuss mobilization of community support for mothers and the strengthening of community action groups.

58. WHO also collaborated with the International Paediatric Association in the organization of an international symposium (Ankara, November 1982) that dealt with a wide range of issues including trends and factors affecting breast-feeding, early weaning and its consequences, lactation and fertility, the so-called "milk insufficiency syndrome", and the implementation of the International Code of Marketing of Breast-milk Substitutes. The aim of the meeting was to prepare guidelines for action by national paediatric associations.

Breast-feeding surveillance

59. A simplified WHO methodology for the determination of infant and young child feeding patterns, with optional modules for collecting information on contraceptive practices, diarrhoeal diseases, respiratory infections, and immunization, has been successfully applied in a number of countries with a view to establishing a sound basis for effective action. Experiences and problems encountered in pre-testing this methodology in Jamaica, Paraguay, Portugal, and Sri Lanka were reviewed at an evaluation meeting attended by a group of experts representing a variety of disciplines, in Jamaica in May 1982, in order to refine the methodology. The results obtained from the surveys conducted in these four countries are summarized in Table 3.

1 Document MCH/BF/SUR/81.1.
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THIRTY-SEVENTH WORLD HEALTH ASSEMBLY

TABLE 3. PERCENTAGE OF BREAST-FED INFANTS, BY AGE, IN URBAN AND RURAL AREAS OF SELECTED COUNTRIES

<table>
<thead>
<tr>
<th>Country</th>
<th>Age in months</th>
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<tbody>
<tr>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12</td>
</tr>
<tr>
<td>Jamaica</td>
<td>(urban) - - 96 91 95 50 ---61---- ---41---- -</td>
</tr>
<tr>
<td></td>
<td>(rural) - 95 100 100 93 93 ---84---- ---61---- -</td>
</tr>
<tr>
<td>Paraguay</td>
<td>(urban) 97 80 73 70 47 70 53 67 37 50 30 27 -</td>
</tr>
<tr>
<td></td>
<td>(rural) 100 97 90 90 80 93 97 77 73 77 80 53 -</td>
</tr>
<tr>
<td>Portugal</td>
<td>(urban) - 76 51 56 35 32 14 21 13 9 5 3 2</td>
</tr>
<tr>
<td></td>
<td>(rural) - 78 64 51 29 39 34 18 23 22 12 22 15</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>(urban) 96 95 93 82 80 73 68 70 57 52 61 59 50</td>
</tr>
<tr>
<td></td>
<td>(rural) 100 98 96 95 92 89 95 93 90 92 82 84 89</td>
</tr>
</tbody>
</table>

60. Based on the evaluation of experience in these four countries, the methodology was modified with special regard to sample design and organizational instructions. A data analysis section was also added to the main text. Following application of the revised methodology, the principal national investigators met again in Geneva in November-December 1983 to develop a common reporting format and draw up guidelines for the preparation of the overall report on national results.

61. A series of regional training workshops has been scheduled for personnel from national ministries of health to accelerate and facilitate the use of the WHO methodology in the African, South-East Asia, and Eastern Mediterranean Regions: in Abidjan, in November 1982 for participants from Congo, Ivory Coast, Madagascar, Mali, Niger, Upper Volta, and Zaire; in Manama in February-March 1983 for participants from Bahrain, Egypt, Jordan, Kuwait, Qatar, Somalia, Sudan, and Yemen; and in Colombo in late 1984 for participants from Burma, India, Maldives, Nepal, Sri Lanka, and Thailand.

62. Workshop programmes include exercises in the setting of objectives; choice of survey methods and steps in survey development; data specification and handling, including use of appropriate microcomputer technology; sampling principles with special reference to cluster sampling techniques; and data analysis and reporting. A "mini-survey" is also carried out by participants in the city where the workshop is organized.

63. These regional workshops have stimulated the development of infant feeding surveillance systems in a number of countries, and have afforded considerable opportunity for collaboration among investigators. In the spirit of TCDC, national investigators are increasingly serving as consultants to help in the design and evaluation of surveys in other countries.

64. Countries currently adapting the WHO methodology to national surveillance needs include Bahrain, Botswana, Brazil, China, Ecuador, Kenya, Kuwait, Lesotho, Libyan Arab Jamahiriya, Malawi, Mauritius, Romania, Togo, Uganda, and Zambia.
Feeding mode and infant morbidity and mortality

65. Few systematic studies have been undertaken on the relationship between infant feeding practices and infant morbidity and mortality. More precise information is needed to guide policy-makers and health workers in promoting better infant and young child feeding practices as part of systematic health activities. WHO, in collaboration with the University of Pelotas, Brazil, and the London School of Hygiene and Tropical Medicine, is currently developing a protocol for cross-control studies of infant mortality in relation to feeding practices and environmental and socioeconomic factors.

66. An in-depth study of the relationship between feeding mode and respiratory disease morbidity was undertaken in Turkey in June 1982. A second phase of the study is designed to examine the role family planning visitors and nurse/midwives can play in the promotion of breast-feeding as a prophylactic intervention. The retrospective component of the study is being carried out at the Hacettepe Children's Hospital in Ankara where in-depth interviews are conducted with parents or guardians of all infants diagnosed as having gastroenteritis or bronchopneumonia. The prospective component is being conducted in two low-income periurban areas.

67. While studies conducted in developing countries have shown that mortality and morbidity are higher among bottle-fed than among breast-fed infants, the situation is more complex in industrialized countries where infant formulas are readily available and relatively cheap, and where sanitary conditions, including safe water, prevail. A number of recent studies conducted in industrialized countries suggest that breast-fed infants have a lower incidence of morbidity than artificially fed infants, while others show no clear difference. These and similar studies have been reviewed and discussed in a paper prepared by the Regional Office for Europe in 1982.1 It concluded that, while most of the studies appeared to show a higher incidence of certain diseases in non-breast-fed infants in industrialized countries, including diseases of the gastrointestinal tract and the respiratory system, most also had a number of methodological weaknesses. Work is now under way with the assistance of experts from several countries of the Region on the preparation of a more suitable model for this type of investigation.

Additional examples of national action

68. Numerous examples of national action being taken to encourage and support breast-feeding are provided in previous reports to the Health Assembly on infant and young child feeding and nutrition (see also paragraphs 132-216). The following activities are indicative of the wide variety of initiatives being taken by many governments in all regions.

69. In the African Region the multidisciplinary character of the national workshops on infant and young child feeding organized in 1982 and 1983 by the Governments of the Central African Republic, Congo, Malawi, Rwanda, Uganda, and Zaire greatly facilitated the development and follow-up of a number of concrete proposals concerning, for example, appropriate feeding practices, revisions to national labour codes in respect of women and children, and the adaptation of the International Code of Marketing of Breast-milk Substitutes to national circumstances.

70. In the Region of the Americas Argentina has established a task force to promote and coordinate the monitoring of breast-feeding in various regions. In Costa Rica a programme is under way for the establishment of milk banks for infants who cannot otherwise have breast milk. PAHO/WHO is cooperating with Guatemala's National Commission on Breast-feeding in the holding of training workshops for health personnel in matters relating to infant and young child feeding.

71. Surveys have been undertaken in Mexico on physicians' and mothers' attitudes towards breast-feeding, and the results will be used to develop action programmes. In Canada the Federal Government commissioned a survey in May 1982 which sought inter alia to evaluate the impact of national and provincial breast-feeding promotion campaigns. The average national

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1 Evensen, S. Relationship between infant morbidity and breast-feeding versus artificial feeding in industrialized countries: a review of the literature. Copenhagen, WHO Regional Office for Europe, 1983 (unpublished document ICP/NUT 014/6, Rev. 1).
72. The action taken by Nicaragua to promote breast-feeding includes health education of mothers, trainees in primary health care, pharmacy and nursing health teams, and the general public through the mass media. As part of the national strategy and plan of action for breast-feeding promotion in Trinidad and Tobago, all categories of health workers have begun to undergo training in techniques of breast-feeding promotion, and obstetricians have been nominated by all major hospitals in the country to assume responsibility for such activities as part of regular activities in pre-natal care.

73. In the United States of America health objectives for 1990 include a 60% increase in the proportion of women breast-feeding at the time of hospital discharge (to 75%) and when the child is six months of age (to 35%). National measures to promote breast-feeding include: legislation on employment of women (for example, the establishment of flexible work schedules and part-time employment); incentives to employers to establish day-care centres in work sites; and two supplemental food programmes provided by the Department of Agriculture in which breast-feeding mothers receive a greater variety and quantity of food for a longer period than non-breast-feeding mothers.

74. Relevant activities in the South-East Asia Region include those in India where the Government has advised doctors and other health staff in its hospitals to promote breast-feeding by educating women in its advantages and the ill effects of the use of breast-milk substitutes; and by promoting rooming-in so that the newborn child can be kept with the mother. In addition, a programme has been launched through All-India Radio and Television to protect and promote breast-feeding through sponsored programmes prepared by the Ministry of Social Welfare.

75. In the European Region, in view of the important influence nursing and midwifery personnel have on infant feeding practices, the Irish Health Education Bureau, with support from WHO, organized a national nurse tutor's training seminar (Wexford, August 1982) to promote better feeding practices and to develop a plan of action and audiovisual materials for training nurses and midwives in this area.

76. Because the rate of breast-feeding in Poland is decreasing for reasons believed by national authorities to include a saturation of the market with breast-milk substitutes, a programme to educate mothers on the advantages of breast-feeding has been set up by the National Research Institute for the Mother and Child, Warsaw, with the help of the mass media. Surveillance and monitoring of feeding patterns is planned.

77. WHO is supporting research being undertaken by the Institute of Maternal and Child Health in Bucharest on infant and young child feeding patterns. The research is part of a five-year plan of action to determine the prevalence and duration of breast-feeding, the timing of weaning and the type of weaning foods introduced. It also seeks to identify child health indicators in relation to infant feeding practices and to pinpoint gaps in knowledge concerning infant and young child nutrition and health in preparation for the development of a comprehensive national health education strategy.

78. In the Eastern Mediterranean Region, following the regional training workshop hosted by the Government of Bahrain in February-March 1983 (see paragraph 61), a number of surveys are being organized in the Region on prevalence and duration of breast-feeding and patterns of weaning and their relationship to incidence of diarrhoeal disease. The Government of Djibouti has published guidelines for the promotion of breast-feeding in health facilities (see paragraph 187). The special joint programme (Salamatak) for the production of health education materials in the Gulf area has been used to promote breast-feeding in the United Arab Emirates. Coordinated national activities to promote breast-feeding and support appropriate weaning practices are carried out through the mass media and the organization of special demonstrations in maternal and child health centres.

79. In the Western Pacific Region the Government of China is attempting to reverse the trend in some major cities where the proportion of breast-feeding mothers has dropped to 20% or 30%. A reform of institutional and hospital procedures has been carried out where the
routine practice of supplying fluid glucose or cow's milk to newborns six to eight hours after birth has ceased, and mothers are no longer prevented from breast-feeding infants during the first 24-36 hours of life.

80. A national workshop, attended by 50 scientists and planners from all over China, was held in Shanghai in October 1982 with WHO support. The purpose of the workshop was to bring up to date information on recent scientific developments concerning breast-feeding, in particular its role in fertility regulation, immunity, nutrition, and psycho-emotional bonding. The plan of action drawn up during the workshop included a national breast-feeding and fertility survey; the development of a national interregional network of collaborating institutions; preparation of guidelines for health care practices most likely to improve breast-feeding performance; and a survey of factors affecting infant feeding. In March 1983 a second workshop on infant and young child feeding surveillance was supported by WHO.

81. In the Philippines a comprehensive education programme on infant feeding was developed and implemented in 1982-1983 on behalf of officials of the Ministry of Health, health workers generally, and representatives of nongovernmental organizations. The programme includes a survey of knowledge and attitudes among health workers and a series of training seminars for all categories of health workers on how best to support sound infant and young child feeding practices.

82. In the Republic of Korea WHO is supporting a one-year education and information programme (September 1983 - August 1984) intended to encourage breast-feeding. The programme is being executed for the Government by the Korean Citizens' Alliance for Consumer Protection, a nongovernmental organization that is affiliated with the International Organization of Consumers Unions. Its objectives include raising public awareness, through the mass media, of the importance of breast-feeding; developing materials for information and education of the general public on breast-feeding and a manual for training breast-feeding promoters; and conducting training courses for promoters from all relevant sectors.

83. WHO provided support to the National Institute of Nutrition of Viet Nam for a three-day national workshop on breast-feeding in August 1983 and a two-week breast-feeding survey which preceded it.

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

84. Malnutrition and poor health in infancy and early childhood remain fundamental public health problems among many population groups in the world. Despite a growing body of information on the epidemiology of child health problems, especially those occurring in and around the period and process of weaning, there is a dearth of sound knowledge concerning the nature, magnitude and interaction of the various factors.

85. Thus although the weaning period, characterized by important changes in both feeding and child health behaviour, has been identified as the most critical phase for child health, relatively little detailed information is available on the social factors that determine infant feeding practices and care. These factors affect family and community decisions about the care and stimulation of the young child, and without more precise indications health planners will remain hard pressed to formulate appropriate strategies to improve the nutritional and health status of infants and young children.

86. WHO has in recent years undertaken and supported research to identify and examine the various determinants of infant and young child feeding and care. A meeting on this topic was held (Geneva, 5-9 December 1983) to review current knowledge in this area, including research results; discuss approaches that have been taken in studying related phenomena, while identifying those methods and techniques that have demonstrated the greatest potential for increasing knowledge; and prepare suitable guidelines for the development of protocols for the study of household factors that determine related behavioural patterns.

87. Participants included some 30 economists, social psychologists, anthropologists, nutritionists, paediatricians, and other representatives of the social and natural sciences, most of whom are engaged in research in related fields. The survey guidelines prepared at
that meeting, which are intended for use in countries prior to specific health and nutrition activities, will be published together with the final report and selected background and research material. It is also planned, as part of a four-year research component of the Joint WHO/UNICEF Nutrition Support Programme (see paragraphs 52-55) to develop these guidelines further, adapt them to country needs, conduct training seminars concerning their use in minimizing weaning problems, and support regional and national centres in evaluating results.

(See also paragraphs 100 and 101 for further information on weaning practices).

Examples of national action

88. There is a need for national surveys to establish the nutritional status of certain population groups, and the Ministry of Health in Ghana is carrying out such an exercise with the FAO/WHO/OAU Regional Food and Nutrition Commission for Africa based in Accra. Particular attention is being paid to the problem of vitamin A deficiency in selected groups, particularly in the northern half of the country. Another collaborative effort between the Government and WHO concerns the preparation of a food and nutrition project to be implemented in the Northern Region under the direction of the Ministry of Finance and Economic Planning.

89. In addition to taking steps to monitor compliance with the International Code and to protect and promote breast-feeding, the Government of Sierra Leone is reactivating production of a protein-rich weaning food which is well tolerated by almost all infants and young children, but which has so far been produced in very small quantities because of the non-availability of raw materials and machinery.

90. Other examples of national action in the African Region include an elaborate year-long information campaign carried out in the Ivory Coast that used all available means of communication to reach the public with messages concerning appropriate infant and young child feeding practices. A variety of related research activities were undertaken in Botswana, Ethiopia, Kenya, Madagascar, Mauritius, Nigeria, Senegal, Zambia and Zaire. Guidelines on appropriate feeding practices were also prepared in Guinea, Mozambique, Uganda, and Zimbabwe.

91. A PAHO/WHO-supported project in Colombia is examining current infant and young child feeding patterns from birth to 36 months of age; associated socioeconomic, cultural, and biological factors; and the relationship between feeding practices and nutritional status. It seeks to identify specific problems in child feeding patterns that are open to improvement through community-based action, either by individuals or through the primary health services, and to develop a simple methodology for the evaluation of these patterns.

92. In some major cities in China, planned diet programmes are being implemented in selected nurseries and kindergartens, where the food is carefully chosen to match the needs of different age groups. The manufacture and supply sectors are at the same time required strictly to observe the principles and regulations of food hygiene laid down by the State in production, packing and advertising. Appropriate food and nutrition standards are being developed in order to ensure the health of the country's infants and young children.

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

93. One of the fundamental principles of primary health care is the participation of the community at all stages. For communities to be intelligently involved, they need to have access to the right kind of information, in a language they can understand, concerning their health situation and how they themselves can improve it. 1

94. In view of the growing need for appropriate materials for education and information on health protection, breast-feeding, and maternal and child health and nutrition, WHO is developing such materials for adaptation and use at the national level by health planners and workers, and others for use by groups (e.g., women's organizations) and individuals.

95. Guidelines for health administrators, policy-makers and health workers are being prepared on the management of breast-feeding within the health care system, including practical suggestions on how to initiate and maintain successful breast-feeding from the perinatal period to the completion of weaning. Recommendations for dealing with special problems resulting, for example, from caesarian births, maternal illness, neonatal jaundice, and pre-term births, as well as a number of more commonly encountered problems associated with breast-feeding, are also covered.

96. WHO continues to develop and refine training materials for use in connection with the establishment of national infant-health surveillance within health care systems based on primary health care. The basic WHO methodology (see paragraph 59) is undergoing a second revision and will soon be available in a new, expanded form that is to include sections on questionnaire development and the use of appropriate microcomputer technology; microcomputer software packages are being developed to facilitate data handling and analysis for such purposes. A manual for use in training programmes to introduce national surveillance methodology, and a slide set on relevant lecture themes and proposed exercises in this context, are being prepared in collaboration with the School of Tropical Medicine in Liverpool, England. The teaching and training aids are being developed with a view to facilitating the organization of national training activities independent of outside consultant support.

97. An illustrated promotional booklet entitled Women and breast-feeding was produced by WHO in 1983 with funds provided in part by SIDA/SAREC (Swedish Agency for Research Cooperation with Developing Countries). It deals with a number of major factors affecting women who breast-feed, for example workload and time allocation, family structures, information availability, health care practices and women's health generally; women's rights; social support measures; and the role of women and women's organizations in promoting breast-feeding and in bringing about improvements in conditions affecting women's lives as a means of making breast-feeding both feasible and rewarding.

98. WHO and UNICEF have taken a new initiative in public information on infant and young child feeding and care: the preparation and wide distribution of attractive, full-colour wall calendars. The 1983 calendar, entitled 'Breast-feeding . . . the modern way', featured mothers and infants of a wide range of nationalities and ethnic groups, and included brief messages emphasizing the appropriateness, naturalness, convenience, etc., of breast-feeding. The 1984 calendar, "A healthy start", was expanded to include 12 interrelated themes for action in maternal and child health: child spacing, pregnancy care, nutrition during pregnancy, immunization for mothers, breast-feeding, growth monitoring, weaning, immunization of children, hygiene, active bodies - healthy minds, safe and clean water, and children's health - tomorrow's health. Each theme was illustrated by a photograph taken especially for the calendar and, as for the previous year, a brief educational message was prepared for each month.

99. Separate English, French, and Spanish versions of the calendar were prepared in 1983, and an Arabic version was introduced in 1984. They have been distributed to and through ministries of health, maternal and child health and family planning clinics, and nongovernmental organizations all over the world.

100. In 1980, as part of its action-oriented research and development activities in nutrition, WHO undertook to produce a set of materials that would help health workers and others in developing countries to study the weaning process. One of the results of this effort was the preparation, in collaboration with the Department of Human Nutrition, London School of Hygiene and Tropical Medicine, of the first draft of a document entitled Studying weaning: a guide for workers in health, welfare and development programmes. The guide is divided into 10 sections, and includes a review of what is known about the weaning process, indications concerning preparations to be made for studying it, and what data to collect and how. It is being revised to take into account the comments made during a critical review by a number of specialists in the field.

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1 Document NUT/83.1.
101. A paper was commissioned in 1983 by WHO on the topic of women and the weaning process and prepared by the International Center for Research on Women, based in Washington. It analyses the broad context of weaning from a women's perspective and summarizes much of the current literature on the effects of women's work and mothering roles on infant and young child nutrition.

102. As part of the Joint WHO/UNICEF Nutrition Support Programme (see paragraphs 52-55), a global review is under way of teaching/learning materials in nutrition and related topics. The purpose of this review is to evaluate available materials and identify those that could be readily packaged and distributed as core materials for local adaptation and use in training programmes and other educational activities in countries participating in JNSP. The review covers many topics including maternal nutrition, the identification of at-risk children in the home and clinic, and weaning techniques. A special effort is being made to identify materials written in languages other than English, as well as those prepared for use by and for those who cannot read.

103. The materials selected will serve to complement the various training modules included in WHO guidelines1 that have been prepared on such topics as measuring and monitoring the growth and nutrition of children; promotion and protection of breast-feeding; advice on the feeding of young children; nutrition care of mothers; identification, management and prevention of common nutrition deficiencies; and nutrition care in diarrhoea and other common infections.

104. As an additional teaching/learning aid, WHO is applying the managerial technique of flow chart preparation to the identification and resolution of specific nutrition problems. Designed to facilitate decision-making, such devices have been used successfully in the training of health personnel in other subjects. Following problem definition, various options are presented so as to facilitate the establishment of cause/effect relationships leading to a solution. The flow charts will be field tested in 1984 and revised, prior to final distribution, on the basis of practical experience.

Examples of national action

105. In Ethiopia education kits for the appropriate feeding of infants and young children have been developed for the public, teachers, health workers, and other community workers. In addition, the translation into Amharic and distribution of the WHO breast-feeding brochure (see paragraph 113) has been completed and the revision of the curriculum for the training of health workers in the feeding of infants and young children is nearing completion.

106. Within the context of an FAO-supported project in Somalia for integration of women in agricultural and rural development, an adapted Somali version of the Manual on feeding infants and young children has been produced.2 The first edition of this manual was produced in 1971 for the former Protein Advisory Group of the United Nations system (PAG) which was co-sponsored by WHO, UNICEF, FAO, and the World Bank (see also paragraph 192).

107. In the context of its review of the International Code for adaptation to local circumstances (see paragraphs 147 and 148), the interministerial committee established by the Government of Zimbabwe decided that it was necessary to study the relevant educational materials on infant and young child feeding already available in the country. A subcommittee charged with visiting the provinces and reporting back with its recommendations found that most material was produced by the manufacturers of infant formula, and therefore took the form of advertising; that all material was in English; and that the promoters of nutrition education lacked teaching aids. As a result, it was decided that the Ministry of Health must undertake to produce more suitable educational materials to promote breast-feeding, good weaning practices, and so on, the only difficulty being the lack of graphic artists on the staff of the Ministry.

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108. PAHO is supporting a national task force's efforts in Argentina to promote and coordinate the monitoring of breast-feeding through the development of training manuals on clinical management and encouragement of breast-feeding.

109. The Clearinghouse on Infant Feeding and Maternal Nutrition, a project of the American Public Health Association that is funded by the Office of Nutrition of the United States Agency for International Development, collects information on infant feeding and maternal nutrition for dissemination to policy-makers, health professionals, programme planners, research workers, and other interested groups and individuals. Two items are of interest in this connection. One is a biannual report, based on information gathered directly from governments, reports, and journal articles, on the present status of breast-feeding support programmes, policies and legislation regarding women in the work force, supplementary feeding, public education and health services, and the marketing of breast-milk substitutes. The first issue (June 1983) contained information in respect of 103 countries. The second item, a newsletter entitled Mothers and Children, is published three times a year in English, French and Spanish.

110. In Bulgaria books and pamphlets on breast-feeding were published in 1983, and a national conference was held on the subject. Press, radio and television provided information on breast-feeding and the correct use of infant formula. In future, postgraduate medical curricula are to include information on the importance of breast-feeding.

111. Two information circulars are being prepared in France, one for maternity ward personnel and the other for maternal and child health staff, drawing attention to relevant provisions of the International Code of Marketing of Breast-milk Substitutes. A pamphlet for mothers on the management of breast-feeding is also being produced, and studies are being undertaken, as a first step in the development of a national breast-feeding strategy, to assess the frequency and duration of breast-feeding and to determine the psychological and socioeconomic factors that affect breast-feeding.

112. An addendum to the Norwegian voluntary code of marketing of breast-milk substitutes (see paragraph 176) provides detailed information concerning inter alia the advantages of breast-feeding and the properties of breast milk; maternal nutrition; preparation for and maintenance of breast-feeding; problems connected with mixed feeding and attempts to re-start breast-feeding; and the appropriate use and preparation of breast-milk substitutes.

113. The Directorate of Health in Portugal, in agreement with WHO, has prepared a brochure on breast-feeding (Aleitamento materno: a alimentação perfeita de seu filho). It is based on the text and illustrations of a WHO brochure, first prepared in 1980, that is now available in Amharic, Arabic, Dari, English, French, Portuguese, Pashtu, and Urdu.

114. In Tunisia the national committee responsible for studying infant feeding problems and adapting the International Code of Marketing of Breast-milk Substitutes (see paragraph 193) to the national context is continuing the work begun with its creation in 1980. In addition to activities related to maternal education, the dissemination of information to the public via the mass media, and informing and training health personnel, the committee has distributed the International Code to the Ministries of Economy and of Finance, to pharmacists, doctors and private clinics. Recent changes in the civil service provide for an extension of maternity leave to eight weeks, with the possibility of an additional 16 weeks at half salary, on request.

115. Attention is being paid in China to communication and education on nutrition, using films, slides, posters, magazines and books to spread knowledge of the principles of infant and child nutrition and welfare. It is intended to increase activities in this respect in the years to come, in collaboration with WHO, UNICEF, UNFPA and other international bodies, with the aim of ensuring that by 1985 80% of all mothers will be breast-feeding their babies for the first four months.

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1 In Ethiopia.
2 In Afghanistan.
3 In Pakistan.
116. Following the recent adoption by the World Health Assembly of resolutions dealing with infant and young child feeding and nutrition, the Ministry of Health in the Libyan Arab Jamahiriya issued directives to the health secretariats in the country's 25 municipalities on the need to actively promote breast-feeding and to avoid the unnecessary use of breast-milk substitutes. A booklet on infant feeding has been prepared and distributed, together with the Arabic version of the WHO brochure on this topic and the International Code (see paragraph 113).

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

117. Recent activities, many undertaken jointly by WHO and UNICEF, in respect of the development of support for improved health and social status of women have concentrated on achieving three main objectives: (1) improving awareness and understanding of how women are affected by such factors as sociocultural values, work patterns and economic constraints, their health and nutritional status, reproductive patterns, and family structures; (2) increasing involvement of women's organizations in the promotion of appropriate infant and young child feeding practices as part of primary health care; and (3) promoting national and community support for women and families.

118. Activities within this programme have, in turn, contributed to WHO's larger programme approach to women in 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 way in which women affect and are affected by health and development, in particular as regards their socioeconomic and cultural status.

Social support measures

119. The promotion of adequate social measures to support women in the performance of their multiple roles, especially in relation to their functions as mothers and members of the work force, contributes to overall efforts to protect and enhance women's health and the health of those who are dependent on them. WHO action in this respect includes promotional and educational activities, and the support of relevant research at the country level. Particular attention is being paid to the impact women's roles are having on infant and young child feeding and care (see paragraph 126).

120. WHO sponsored the development in 1983 of a survey methodology that is intended for use in the preparation of country case studies for analysing and evaluating the effectiveness of formal and non-formal social support measures for women; and for identifying alternatives where such measures are lacking or inadequate. The methodology is designed to ensure the involvement of women and their organizations in the investigation and analysis of problems affecting them.

121. The case study methodology is being applied for the first time in Kenya, with support from WHO, by the local breast-feeding information group under the guidance of the Ministry of Health. The group seeks to identify the problems faced by working mothers in regard to breast-feeding, complementary feeding, and child care; determine what traditional and modern social and economic support measures are already available to women; learn from women and employers alike how problems that are identified might be solved; and formulate recommendations for increased support for working women from private and public bodies. The draft report of the field study, minus policy and other recommendations currently being prepared, was completed and circulated among members of the group and other interested parties in February 1984. The full report, which summarizes the responses of nearly 1100 women aged 15 to 59 who work in and around four different cash crop plantation areas, will be available later in the year.

122. Elsewhere in the African Region an assessment of the needs and problems associated with village-based day care arrangements in Ghana, Liberia and Nigeria has been undertaken with a view to improving their effect on the organization of women's time and on the nutritional and social development of their children. WHO jointly with UNICEF organized a meeting on day care, in Nairobi in November 1982, and has prepared two offset documents: A report on
alternative approaches to day care for children\(^1\) and an Annotated bibliography on day care for children.\(^2\)

123. WHO continues to review legislation in different countries for facilitating and supporting breast-feeding, especially by working mothers, in accordance with the Health Assembly's request in 1980.\(^3\) Appropriate texts are regularly covered in the quarterly International Digest of Health Legislation.

124. On a wider scale, WHO has collaborated with ILO in the preparation and printing of a survey of existing maternity protection legislation in 129 countries.\(^4\) Funds for this purpose were provided, in part, by UNFPA and SIDA/SAREC. The portion of the introduction prepared by WHO, concerning the health and nutritional requirements of working women, emphasizes the need to extend coverage of maternity protection legislation, in terms both of the target population reached and of the cash and other benefits provided, including an increase in the duration of maternity leave and the time and facilities accorded for adequate breast-feeding. The important role such legislation plays in terms of prevention and health promotion is stressed within the context of primary health care. Costs of such measures, it insists, must be weighed against the potential social and economic benefits accruing to the individual, the family, and society as a whole through a reduction in maternal, infant and child morbidity and mortality.

125. WHO is collaborating with the Women and Development Division of the Commonwealth Secretariat in the development of a cost/benefit framework, intended for use by decision-makers, for assessing the return on investments made in social support for women. A number of health economists and research workers studying women's economic and employment status reviewed material on the subject at a meeting in London in November 1983 that was co-sponsored by WHO; they concluded that it was possible and desirable to make such assessments. However, more precise definitions were required; these are to be incorporated in an advocacy paper on the subject to be prepared later in the year by the Commonwealth Secretariat in cooperation with WHO and UNICEF.

126. The Joint WHO/UNICEF Nutrition Support Programme (see paragraphs 52-55) has a specific women's component which stresses their particular needs and the needs of those dependent on them. Action at national level is being promoted in this context, including income-earning activities for women to enhance the capacity of families and communities to meet their own health and nutritional needs. Additional areas of emphasis include the development of appropriate technologies for food handling, preparation, and storage; finding solutions to problems of child care; and education in family nutrition. This element of JNSP seeks a sensible compromise between women's mothering responsibilities and their involvement in more directly economic activities so that women can fulfil their potential as fully productive partners in the development process.

127. Other related developments are reported on elsewhere in the present report, for example the paper on women and the weaning process (paragraph 101); the illustrated promotional booklet, Women and breast-feeding (paragraph 97); and the WHO/UNICEF wall calendars for 1983 and 1984 on themes of maternal and child health (paragraphs 98 and 99).

APPROPRIATE MARKETING AND DISTRIBUTION OF BREAST-MILK SUBSTITUTES

128. The protection and encouragement of breast-feeding is an important aspect of the health, nutrition and other social measures required to promote healthy growth and development of infants and young children. As one such measure, the Thirty-fourth World Health Assembly in May 1981 adopted the International Code of Marketing of Breast-milk

\(^1\) Document MCH/DC/81.1.

\(^2\) Document MCH/DC/82.1.

\(^3\) Resolution WHA33.32, paragraph 6(6).

Substitutes in the form of a recommendation, and urged all Member States inter alia to translate it into national legislation, regulations or other suitable measures; to involve all concerned parties in its implementation; and to monitor compliance with it.1

129. The International Code provides for reports by the Director-General to the Health Assembly in even-numbered years on the status of its implementation (Article 11.7). In addition, the Assembly requested the Director-General to report to it 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".1

130. Accordingly, the Director-General reported to the Thirty-fifth World Health Assembly in May 1982 on steps taken by Member States to give effect to the International Code, and to the Thirty-sixth World Health Assembly in May 1983 on the status of compliance with it. The latter report concluded that, in the light of the information on the implementation of the Code available from Member States since its adoption, and in the absence of any suggestions by them for change, it would have been premature at that time to have proposed any revision of the text of the Code, its form or content. The Health Assembly unanimously endorsed this conclusion and took note of the report by the Director-General.

131. What follows, in this second biennial report to the Health Assembly on the status of implementation of the Code since its adoption, is a summary of information provided for the most part by Member States themselves on action they are taking to give effect to the Code. The information is presented by region in alphabetical order of country or territory; it is limited to developments occurring since the preparation of the report by the Director-General to the Thirty-sixth World Health Assembly. It should, therefore, be read in conjunction with this latter report, as well as in the light of the previous biennial report submitted to the Thirty-fifth World Health Assembly (see paragraph 51 for document references). Together, the three reports provide an overall view of the steps that have been taken by some 130 countries and territories individually and, in a number of cases, collectively through regional and interregional forums, to give effect to the principles and aim of the International Code.

**African Region**

132. The Government of Benin expects to integrate the International Code into its national food legislation by expanding the basic law in this respect. Meanwhile the advertising of breast-milk substitutes to the general public is not permitted.

133. The advertising of breast-milk substitutes through the mass media has been banned in Ethiopia.

134. The Kenya Code for Marketing of Breast-milk Substitutes2 is described, in its preface, as "essentially an adoption" of the International Code. It applies to the quality, availability, and information related to breast-milk substitutes, feeding bottles and teats. It includes the message that mothers should be encouraged to breast-feed exclusively for four to six months provided satisfactory growth and development are sustained, and that they should be encouraged to continue breast-feeding for as long as possible after the introduction of complementary foods at four to six months. The Code highlights inter alia the role of the Ministry of Health in monitoring its application, while at the same time referring to the responsibilities of manufacturers, nongovernmental organizations, professional groups, institutions and individuals concerned.

135. An interministerial committee in Liberia has recommended that the promotion of breast-feeding be considered a major component of the draft national food and nutrition plan. Following the plan's submission for comments to all interested parties, and formal approval by the responsible national authorities, it will form part of the overall national development plan.

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1 Resolution WHA34.22.
136. The Ministry of Health and Social Welfare has prepared draft national legislation in accordance with the guiding principles contained in the International Code. This draft was submitted to the above-mentioned interministerial committee for comments which are now under consideration with a view to finalizing the draft legislation.

137. Existing teaching materials on the promotion of breast-feeding are being reviewed and new ones developed, while an information campaign on breast-feeding was initiated in 1982 on television and radio in collaboration with the Ministry of Information. Advertising of breast-milk substitutes in these media has been restricted.

138. WHO cooperated with the Government of Malawi in December 1982 by providing a paediatrician and a lawyer to participate in its week-long national workshop on infant and young child feeding that included a discussion on the development of national measures to give effect to the International Code.1

139. In order to facilitate the drafting of legislation to give effect to the International Code in Mali, it was decided to establish an interministerial committee to study ways of adapting it to local conditions. The committee recommended carrying out an inquiry during 1983 into breast-feeding in both rural and urban areas. The results of the inquiry are to be the subject of a national debate, and measures adapted to the conditions of the country will be taken by common consent.

140. Following the recommendations made by a workshop on infant and young child feeding organized in April 1982, the Government of Rwanda has set up a committee to draft legislation that is to be entirely based on the International Code, the only modifications being designed to bring the relevant provisions into conformity with the social and economic conditions prevailing in the country.

141. The advertising of breast-milk substitutes to the general public is not permitted in Sao Tome and Principe.

142. The Ministry of Health in Sierra Leone has taken steps to halt advertising for foods for infants that infringes the provisions of the International Code and is at variance with current teaching. The International Code is to be published as a Government Notice, which will make its provisions mandatory for importers and distributors of foods for infants. The media are used for educating the public on infant feeding, and it is planned to set up a committee, comprising eight professionals from the Ministry of Health and the Law Officers Department, to monitor compliance with the International Code.

143. In Togo a survey is being undertaken of products specifically intended for the nutrition of infants and young children in urban centres; there is indiscriminate sale of such products, which are stored under conditions that are not always adequate. It is anticipated that the results of the survey will make it possible to determine the measures needed for introducing order into the conditions of storage and sale of products for nursing infants and young children.2

144. Measures to implement the International Code in Uganda have included a seminar organized by the Uganda branch of the Inter-Parliamentary Union, WHO and UNICEF in March 1983, with the aim of making parliamentarians, policy-makers, and the general public aware of the issues involved in child nutrition, and particularly of the importance of breast-feeding and good weaning practices. As a follow-up, an intersectoral workshop was scheduled for the following July to work out a national code of marketing and the regulations to enforce it. Some of the regulations are to come under the Bureau of Standards Act, others under the Dairies Act and the Advertising Act. A national survey to determine patterns of breast-feeding and weaning was planned for late 1983 to facilitate the development of an appropriate code and regulations.

145. The Government of the United Republic of Tanzania instructed the secretariat of the National Food Control Commission to draft a national code in respect of the manufacture and

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2 See paragraphs 217-220 concerning the storage of products used specifically for infant and young child feeding, particularly in tropical countries.
marketing of infant formula and other foods used for the feeding of infants and young children, following the adoption of the International Code. The Chairman of the Commission requested technical support from WHO for an appraisal inter alia of national needs for breast-milk substitutes and the form that national action might take to give effect to the International Code. WHO responded by providing the services of two temporary advisers, a nutritionist and an international lawyer, for a period of two weeks in January 1983.

146. A national code of marketing is ready for submission to the responsible government authority in Zambia. Certain sections of it, which do not require the enactment of legislation, are already being applied in the national network of maternal and child health centres.

147. A representative of the Legal Division of the Commonwealth Secretariat was invited to Zimbabwe in connection with preparations for the interregional workshop in January 1983 on the implementation of the International Code (see paragraph 107), to examine the situation and to make recommendations on legal aspects of the adoption of the Code and the adaptation of existing legislation.

148. A draft Zimbabwean Code on the marketing of breast-milk substitutes was submitted to the Ministry of Legal Affairs for advice on how it could best be enacted. Views are being solicited from ministries, nongovernmental organizations and manufacturers on the advisability of amending present legislation by a new bill or adopting a separate Act of Parliament, before any definitive recommendations are made to the Ministry of Health. In the meantime, the Ministry has produced guidelines, which have been circulated to health workers, institutions, and manufacturers. Criteria for the provision of breast-milk substitutes have also been drawn up and circulated.

Region of the Americas

149. In Canada the advertising of breast-milk substitutes to the general public through the printed media has been discontinued by voluntary agreement between magazine publishers and the infant-food industry. Advertising to health professionals, while of less concern, is said still to be a problem. Revised regulations covering inter alia quality aspects and labelling requirements in respect of "human milk substitutes" (infant formulas) were issued on 9 December 1983. ¹

150. As part of the Federal Government's survey to evaluate breast-feeding promotion programmes (see paragraph 71), an effort was made to assess the extent of the practice of making donations of infant formula samples to mothers. There appears to be some selectivity on the part of hospitals. About 70% of the breast-feeding mothers surveyed indicated they had received a sample of infant formula, although there were considerable regional variations (down to 50%). When sample receivers were compared with nonreceivers, the proportion of the former who stopped breast-feeding in the first month was found to be two to three times higher. The results of this survey are being brought to the attention of key health professionals and institutions.

151. In Costa Rica a national code of marketing of breast-milk substitutes, based on the International Code, has been drawn up by a technical group and approved by the Ministry of Health. It is being reviewed by the Ministry's Legal Department for incorporation into national health law.

152. A regional consultation on the formulation of legislation concerning the appropriate marketing and distribution of breast-milk substitutes was held in December 1982 with the participation of health authorities from Dominica, Grenada, Saint Vincent and the Grenadines, and the Turks and Caicos Islands, and with the collaboration of the Caribbean Food and Nutrition Institute.

153. In April 1983 the Ministry of Public Health of Ecuador drew up draft regulations on the marketing of "foodstuffs for nursing infants", and for children under the age of one year. These regulations, covering breast-milk substitutes, dietetic food products, and supplementary or weaning foods, were scheduled to come into force during the second half of the year.

154. The regulations provide inter alia that official approval has to be obtained from the health authorities before marketing and advertising can be undertaken. Labels, in Spanish, are required to state clearly that the products do not replace mother's milk and have to be prepared exactly in accordance with instructions. The use of such terms as "humanized" and "maternalized" and of pictures implying that the product in question replaces mother's milk and is just as good are prohibited. Advertising of breast-milk substitutes can be directed only to paediatricians and only through the scientific literature; all forms of advertising to the general public are strictly forbidden.

155. A draft code of marketing of breast-milk substitutes has been approved in Guatemala by the Legal Department of the General Administration of Health Services. It has been submitted to the Presidency of the Republic by the National Commission on Breast-feeding.

156. Compliance with the December 1981 Law for the promotion of breast-feeding in Nicaragua is being supervised by the Mass Media Authority in coordination with the Ministry of Health, and no such advertising took place in 1982. The use, composition, price and distribution of breast-milk substitutes, considered as medical supplies, are monitored by an Intersectoral Committee on Pharmaceutical Products, while quality control of imported products, and of the stocks kept by retail and wholesale distributors, is carried out by the National Institute of Hygiene and Epidemiology.

157. As a complement to the decree of December 1981 concerning the promotion of breast-feeding, a national code is being prepared in Nicaragua in conformity with the principles and aim of the International Code.

158. Some of the specific approaches to the marketing of breast-milk substitutes set forth in the International Code are in effect in the United States of America as a result of voluntary decisions by the major infant-formula manufacturers. For example, there is no advertising of infant formula through the mass media. Each of the three major companies has its own code of conduct where the marketing of infant formula is concerned, and all three have declared that they will abide by the International Code in the course of their business operations in developing nations, while continuing to review their practices in industrialized countries.

159. The United States Government has reported that it has not taken legislative action regarding the provisions of the Code because many of its provisions have already been accepted on a voluntary basis; because it considers that some of its provisions are inappropriate to prevailing economic and social circumstances, which are different from those in the developing nations - the primary target of the Code; and because of certain United States legal and constitutional provisions. The Government of the United States of America has concluded that action by it to enforce particular provisions of the Code is inappropriate in the context of United States law and policy. The Government has no objection to voluntary decisions by national companies to adhere to particular provisions of the Code, but it would not legislatively implement provisions that run counter to existing policy.

160. As regards labelling modifications, United States manufacturers have adopted symbols and pictograms to supplement directions for proper and sanitary preparation, and a universal dilution symbol is being used industry-wide for placement on labels of all concentrated infant formulas. The symbol, which is in the same colours and location on all concentrated formula labels, is intended to assist illiterate or non-English-reading parents to understand the proper preparation of the formula. Information materials provided to health professionals are produced in both English and Spanish and, when requested, in other languages such as Khmer and Vietnamese. These materials stress the value of breast-feeding and how to accomplish it, and instruct parents on proper preparation of infant formula.

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161. On a related matter, the United States Food and Drug Administration (FDA) and the Consumer Product Safety Commission announced in December 1983 steps\(^1\) to reduce nitrosamines found in rubber baby-bottle nipples (teats)\(^2\) and pacifiers (dummies) to the lowest possible level. Data show that nitrosamines, which are formed during the manufacturing process, can migrate into milk or other food or through direct saliva contact and be ingested.\(^3\) The action level set by the FDA will require nipples to achieve nitrosamine levels below ten parts per thousand million by 1 January 1985.

162. By resolution No. 5 of 16 July 1982,\(^4\) the Ministry of Health and Social Welfare in Venezuela adopted requirements to be fulfilled by infant formulas. Accordingly, the superiority of breast milk must be stated on containers, wrappers, labels and accompanying leaflets, and in legends and advertisements for infant formulas, as must the fact that the latter may be substituted for breast milk only under medical supervision. Words or illustrations on containers, wrappers, etc., that seek to influence mothers to use these products to the detriment of breast-feeding, or that promote their consumption in an ill-considered manner [de manera caprichosa] and in the absence of medical supervision, are prohibited.

163. Advertising carried out by any communications medium for infant formulas must be limited to educational campaigns and must be examined in advance by the Division of Food Hygiene of the Ministry of Health and Social Welfare. Informational material intended for medical and allied health personnel must be scientific in nature. Finally, the promotion of the sale and consumption of infant formulas by means of, inter alia, bargain offers, posters, or distribution of samples, or in general any kind of gift, is prohibited. Samples may, however, be distributed to medical and allied health personnel.

The Caribbean Community

164. WHO supported the participation of several representatives of regional medico-legal bodies and provided an expert for a meeting in November 1982 of the Caribbean Community's (CARICOM)\(^5\) Standing Committee on Medico-Legal Issues, which examined the International Code and recommended to Member countries ways and means of implementing it.

South-East Asia Region

165. By Order of 19 December 1983, the Government of India adopted the Indian National Code for Protection and Promotion of Breast-feeding\(^6\) as "one aspect of the measures government should undertake to protect and promote the healthy growth and development of infants and young children". Closely resembling the regulation version of the International Code,\(^7\) copies of the national code were directed to be communicated to all concerned, including central and state government officials, and to be published in the Gazette of India for general information.

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\(^2\) Teats are included within the scope of the International Code, under Article 2.

\(^3\) A class of carcinogens in animals, nitrosamines occur naturally at low levels in many foods and may be formed in the human gastrointestinal tract.


\(^5\) Membership of CARICOM: Antigua and Barbuda, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Montserrat, Saint Christopher and Nevis, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago.


\(^7\) See document A34/8 for the regulation version of the International Code of Marketing of Breast-milk Substitutes. The International Code was originally submitted to the Executive Board and to the World Health Assembly, in January and May 1981 respectively, in the form of a regulation and a recommendation. The Code was adopted in the latter form, in the sense of Article 23 of the Constitution of WHO, on 21 May 1981. See document WHA34/1981/REC/1, Annex 3, for an explanation of the legal implications of both forms.
166. In Sri Lanka, Direction No. 44 was published\(^1\) on 8 February 1983 prescribing that "all manufacturers of and/or traders in Infant Milk Foods, Infant Foods, Feeding Bottles and Teats and Valves for feeding bottles shall comply" with the national code for the marketing of these products. In addition to sections dealing \textit{inter alia} with advertising and promotion, labelling, samples and supplies, educational materials, health care systems, company personnel and pricing structures, and quality control and nutritional standards, the code disallows the sale of feeding bottles made of plastic.

\textbf{European Region}

167. In Algeria the local production or importation of breast-milk substitutes is regulated by national legislation enacted over a decade ago. Import procedures applied include the issue of international invitations to tender, prescribing not only the quantities and methods of packaging and dispatch, but also the chemical composition of the product concerned, and requiring the manufacturer to provide information on the results of analyses carried out. Commercial advertising of breast-milk substitutes is forbidden and the state monopoly over foreign trade has eliminated the use of foreign trademarks.

168. In Austria breast-milk substitutes are considered dietetic foods and are subject to food law regulations. The Federal Ministry of Health has drafted a voluntary agreement, in collaboration with the infant-food industry and paediatricians, which deals with advertising and the provision of product samples. A draft of this agreement was first available in March 1983.

169. The Government of Bulgaria has provided information concerning the requirements of the International Code to the state dairy industry, producers and distributors of infant foods, and the National Institute of Health Education.

170. Extensive discussions have taken place in Denmark between national authorities (National Board of Health and Ministries of the Interior and of Foreign Affairs), representatives of health workers' organizations, consumer groups, and the Association of Danish Producers of Dietetic Products (SEDAN) concerning the adaptation of the International Code to local conditions. The Ministry of the Interior announced on 2 February 1984 the adoption of a voluntary agreement with SEDAN which provides \textit{inter alia} for a halt in advertising of breast-milk substitutes to the general public, and a change in product labelling practices, including removal of pictures of infants and inclusion of a recommendation concerning the importance of consulting a health worker before using breast-milk substitutes. In addition, the infant-food industry has announced that it will abide by the terms of the national agreement in respect of its marketing practices abroad. The agreement came into effect on 1 March 1984, and is scheduled to be evaluated in one year's time.

171. On a related issue, SEDAN has informed the Ministry of the Interior that its member companies do not intend to extend or intensify the marketing of cereal-based weaning foods for infants; such a decision gives hope of reducing the risk of early cessation of breast-feeding.

172. In the Federal Republic of Germany the International Code has been sent to the German Hospital Association and to the German Society for Gynaecology and Birth Assistance in order to advise their members about their responsibilities as health workers and members of the health care system, especially with regard to providing information.

173. The implementation of the International Code in Ireland continues as an integral part of a range of research, educational, environmental and control measures the primary objectives of which are to increase the rate of breast-feeding and to ensure that a high level of breast-feeding is maintained. There are indications that the breast-feeding rate on discharge from hospital is on the increase from the 32% registered during the national survey conducted in 1981.

174. A Code of Practices for the Marketing of Infant Formulae in the Republic of Ireland, based on the principles and aim of the International Code, and reflecting the legal, epidemiological, social and economic circumstances relating to the use and marketing of

infant formulas in the country, was adopted on 21 December 1982. It is the result of discussions between the Department of Health and the manufacturers of infant foods based in Ireland and of consultations with a wide range of persons, organizations and groups who have special expertise in infant feeding and child care. A feature of the Code is the establishment of a committee to monitor its application that is composed of experts in infant feeding and child care nominated by their organizations; officials from the Department of Health and the Health Education Bureau; and representatives of the infant-food industry.

175. The main functions of the Monitoring Committee are to examine breaches or apparent breaches of the Code and to review the Code in the light of experience of its operation and any relevant information brought forward. Compliance is to be monitored by medical and paramedical personnel employed in the community health services and hospitals in the primary health care system, who would report to the Monitoring Committee. Reports may also be made by members of the general public.

176. A voluntary code of marketing of breast-milk substitutes was signed by the Government of Norway and the two national manufacturers of infant formula on 6 April 1983. "Guidelines for Healthy Infant Feeding Practices", which have been agreed in meetings between the Directorate of Health and representatives of the five main health worker organizations in Norway, have also come into force. Taken together, these two agreements cover all of the provisions of the International Code, with some adjustments made to allow for national circumstances.

177. After a year's application in Portugal, the national code for the marketing of breast-milk substitutes was modified in August 1983 so as to eliminate the supply of samples and new formula products to doctors and health services. The revised version appeared as Annex 1 to the information booklet Nutrição em Pediatria (Nutrition in paediatrics) published in late 1983 by the Directorate-General of Health and intended for distribution to the health professionals and the public. One of the problems remaining to be solved is the advertising on television and elsewhere of such articles as feeding bottles.

178. The Swedish regulations of 2 May 1983 were issued for the guidance of health and medical care personnel on the implementation of the International Code, in particular in respect of infants up to the age of six months. They include sections dealing with information and education on infant feeding; the health and medical care systems; and health and medical care personnel. In addition, the National Board of Health and Welfare has, in consultation with the National Board for Consumer Policies and the National Food Administration, formulated general recommendations concerning the implementation of the International Code in Sweden.

179. In the United Kingdom of Great Britain and Northern Ireland a code of practice for the marketing of infant formulas, prepared by the Food Manufacturers Federation in consultation with the United Kingdom Health Departments and the Ministry of Agriculture, Fisheries and Food, and a complementary health circular for the guidance of health professionals came into effect on 2 August 1983. A monitoring committee, consisting of eight members to be nominated by the Government from among health professionals and the consumer interests and four members nominated by the Federation, is being established to monitor compliance with the Federation's code of practice.

European Economic Community (EEC)

180. The Commission of the European Communities Directorate General for Internal Market and Industrial Affairs is expected to take final action in the near future on the revised version of the "Industry code of practice for the marketing of breast-milk substitutes in the EEC", which was submitted by the Association of Dietetic Food Industries of the EEC (IDACE) on 5 September 1983.

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181. A representative of the Commission announced on 29 November 1983 that the Commission was about to complete a round of consultations on the subject of breast-milk substitutes with parties concerned, including Member States of EEC and the Advisory Committee on Foodstuffs, in which agriculture, commerce, consumers, industry and trade unions were represented. These consultations were to enable the Commission to present in the near future a proposal to the Council, composed of representatives of the 10 Member States, for a directive on the composition and labelling of infant formulas and "follow-up milks" as stated during a related debate in the European Parliament in April 1983 (see below). The Commission was also currently engaged in the evaluation of other matters relating to infant feeding and intended to submit its conclusions together with this proposal.

182. On 11 April 1983 the European Parliament adopted by a vote of 133 in favour to 23 against a resolution drawn up by the Committee on Development and Cooperation on the International Code of Marketing of Breast-milk Substitutes. The resolution referred to the previous resolution on the topic adopted by the Parliament in October 1981 and recalled that the Commission of the European Communities had given the Parliament an undertaking to draw up a proposal for a directive to ensure uniform application of the International Code in Member States of the Community. It urged the Commission, inter alia, to draw up a proposal for such a directive; to submit to the Parliament an annual report on application of and compliance with the International Code in the Community and by Community-based firms operating elsewhere in the world; and to make all reasonable efforts to ensure that companies based in Member States of the Community operating in developing countries comply with the provisions of the International Code or local legislation and codes in these countries.

Informal consultation with the infant-food industry

183. An informal consultation with 10 representatives of European infant-food manufacturers was convened by the WHO Regional Office for Europe in Copenhagen on 7 December 1983. The main purpose was to provide an opportunity for dialogue between WHO and the infant-food industry concerning relevant nutrition questions in the Region. The International Code and its implementation by manufacturers and distributors of breast-milk substitutes was a central theme. A draft model scheme for evaluation of infant-food marketing strategies, which had been prepared by the Office in response to a general request from the Regional Committee for technical support in this area, was presented in document form and discussed in detail. Other subjects for discussion included "follow-up milks" and the export of breast-milk substitutes to developing countries.

184. It was agreed that the draft model scheme would be reviewed by the manufacturers represented at the consultation and that comments would be forwarded to the Regional Office by the end of March 1984; that the Secretary General of the International Secretariat for the Industries of Dietetic Food Products (ISDI) would in future serve as the contact point between the infant-food industry and the Regional Office; and that it would be useful, at least for a few years, to have annual informal consultations between industry and the Office, preferably in the autumn.

Eastern Mediterranean Region

185. The proposed meeting in Afghanistan of representatives of the Ministries of Public Health, Education, Justice, Trade, and Information, as well as other relevant government bodies and WHO and UNICEF country staff, was held in late 1982 under the auspices of the State Planning Committee. Plans were formulated for the preparation of a draft national code of marketing of breast-milk substitutes by the Ministry of Public Health in cooperation with, in particular, the Ministries of Justice and Trade.

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2 Belgium, Denmark, France, Federal Republic of Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, and United Kingdom of Great Britain and Northern Ireland.
186. Following the adoption of the International Code a committee was established in Cyprus under the Director of the Department of Medical and Health Services to study the Code and adopt provisions to suit national circumstances. The committee, composed of paediatricians, obstetricians/gynaecologists, other health workers, and manufacturers' representatives, has made a number of recommendations which are under consideration by the competent government authorities. Meanwhile, district medical officers and health visitors have been asked to take appropriate action to encourage breast-feeding and to stress its advantages and the disadvantages of using breast-milk substitutes.

187. The Government of Djibouti published instructions\(^{1}\) in October 1981 the purpose of which is to provide persons in charge of health facilities with guidelines for the promotion of breast-feeding. They deal inter alia with information and education that is to be provided to pregnant women and mothers concerning the benefits of, and appropriate techniques for commencing and continuing, breast-feeding; maternal nutritional needs, including emphasis on supplementing the maternal diet in preference to feeding the child with breast-milk substitutes; and the introduction of appropriate complementary foods, by means of a cup and spoon, and the avoidance of bottle-feeding, while continuing breast-feeding until the child is one year old. The instructions also prohibit, in dispensaries, health facilities, and services, any advertising that discourages breast-feeding and suggests that bottle-feeding is preferable.

188. The Government of the Islamic Republic of Iran now exercises a monopoly over the importation and distribution of breast-milk substitutes and has reduced the number of brands available on the local market. Breast-feeding is being encouraged by the clergy, and through the publication of pamphlets and the broadcasting of educational programmes on national radio and television.

189. All containers of infant formula marketed in Israel must carry a notice in Hebrew which reads as follows: "For your attention: breast-feeding is the best food for the infant. When mother's milk is insufficient, or when breast-feeding is impossible, you should give the infant appropriate food". The use of terms such as "humanized", "maternalized" and the like have not been permitted in Israel for many years. No pictures of babies are allowed on labels or containers.

190. In Jordan the technical committee of the Ministry of Health formed to study various aspects of infant and young child feeding is finalizing comprehensive specifications for infant formula and other foods intended for infants and young children up to the age of three years. They cover inter alia relevant WHO recommendations (the International Code) and those of the Codex Alimentarius Commission. The committee has required that manufacturers and importers of infant formula register their products with the Ministry of Health for eventual approval on the basis of their conformity with these specifications. It has also fixed prices for these products.

191. A national code of marketing of breast-milk substitutes has been drafted in Qatar which would inter alia make the availability of infant formula subject to a medical prescription, and provide for the registration of merchants with the Food Control and Research Centre as a condition for being authorized to sell infant formula.

192. In Somalia the International Code has been translated into the Somali language and reproduced as Annex 4 to the adapted local version of the Manual on feeding infants and young children originally prepared for the Protein Advisory Group of the United Nations system (PAG) in 1971 and revised in 1976 (see also paragraph 106).

193. In Tunisia the provisions of Law No. 83-24\(^{2}\) of 4 March 1983 apply to quality control, marketing, and information concerning the use of breast-milk substitutes and related products and to the marketing of feeding bottles and teats. The Law disallows inter alia advertising for breast-milk substitutes and the distribution of samples of breast-milk substitutes and utensils and articles of such a nature as to promote such products or bottle-feeding; demonstrations of artificial feeding, except by health personnel; and donations or sales at reduced prices of products within the scope of the Law, except to child care institutions. With regard to labelling, a boxed legend must emphasize the superiority of breast milk, in


addition to providing information on how to prepare the products properly and indicating the disadvantages of inappropriate use. All information must be in Arabic. The Law is scheduled to come into force within a period not exceeding one year following the date of its enactment.

The Council of Health Ministers of Arab Countries of the Gulf Area

194. In February 1983 the Secretariat General of the Council of Health Ministers of Arab Countries of the Gulf Area convened a meeting in Riyadh to consider implementation of the International Code. WHO was requested to provide technical support for this meeting, which reviewed in detail the provisions of the Code, and made a number of suggestions for amending it to suit the particular needs of member countries.

195. On the basis of a recommendation made by the meeting, the Secretariat General established a committee to consider the International Code and to prepare a common draft law to give effect to it. The draft law, which shows only minor variations from the text of the International Code, was approved by the ministers of health of Arab countries of the Gulf Area during their sixteenth meeting, in January 1984.

Western Pacific Region

196. On 2 May 1983 the Federal Ministries for Health and for Primary Industry in Australia endorsed the Australian Code of Practice for the Marketing of Infant Formulas. The Australian Code gives effect to the International Code, but with one or two modifications necessary to comply with existing national legislation. In addition, the Food Standards Committee of the National Health and Medical Research Council is incorporating Articles 9.1, 9.2 and 9.4 of the International Code into the labelling provisions of an Australian draft standard for infant formulas, while discussions have been held with state health authorities on the health sector's responsibilities regarding the Code.

197. In Brunei Darussalam the medical and health services are promoting public awareness of the advantages of breast-feeding by means of the mass media (radio and television) and through pamphlets, posters, seminars, and exhibitions. The International Code is being applied wherever appropriate to national circumstances. While there is no national legislation dealing with the marketing of breast-milk substitutes, their advertising in the mass media has been stopped. Free milk samples are not distributed in clinics.

198. The Director of Public Health and Social Services of Guam is reviewing both the territory's compliance with the guidelines established in the International Code, with a view to recommending action to remedy any deficiencies or health-related problems found to exist, and the breast-feeding educational assistance programmes, in order to ensure their maximum effectiveness.

199. The Urban Services Department in Hong Kong has advised all importers of infant foods to obtain from the manufacturer and the competent authority of the country of origin a certificate that each consignment of infant food is manufactured in accordance with applicable Codex Alimentarius standards and practices, and complies with the labelling provisions of the International Code (Article 9).

200. In Malaysia the revised version of the national "Code of ethics and professional standards for advertising, product information and advisory services for infant formula", which was originally adopted in June 1980, was launched by the Minister of Health on World Health Day, 1983.

201. New Zealand has announced that it has agreed to the International Code without reservation. Indicating that it prefers a regional approach to the question, the Minister of Health has written to other ministers of health in the South Pacific inviting them to do likewise. By voluntary agreement with marketers and exporters, a legal statement of affirmation is to be signed. The Minister of Health announced in April 1983 that the


International Code was being adopted with the addition of a provision for a monitoring group composed of representatives from government, the health professions, nongovernmental organizations and industry, which will interpret any part of the Code that may cause difficulty. Exporters of breast-milk substitutes will agree to adhere to the domestic code of the country of destination or, in the absence of any such instrument, to the International Code.

202. The Government of the Republic of Korea is encouraging self-regulation by industry in order to implement the International Code. The Ministry of Health and Social Affairs has transmitted its recommendations on the protection and promotion of breast-feeding, with a translation of the Code, to all concerned, including the infant-food manufacturers and voluntary organizations.

203. National health authorities in Samoa have met with the representative of a major manufacturer of breast-milk substitutes to discuss bringing marketing practices into line with certain provisions of the International Code, including information intended for health workers and the content of product labels.

Global, regional and interregional action with respect to the implementation of the International Code

204. In addition to the six official languages of WHO, the International Code has been translated into Danish, Dari,1 Dutch, German, Japanese, Korean, Norwegian, Portuguese, Pushtu,1 Somali (see paragraph 192), and Swedish. With the exception of the translation into German, prepared by the WHO Regional Office for Europe at the request of UNICEF (for the use of its interested national committees in Europe), all of these unofficial translations were prepared outside the Organization by governments, UNICEF, nongovernmental organizations, infant-food manufacturers and others.

205. WHO continues to collect information on laws, regulations, and other measures concerning the marketing of breast-milk substitutes in accordance with the Health Assembly's request made in 1980.2 National measures covered in the International Digest of Health Legislation during the period encompassed by this report include those from Canada, Djibouti, Kenya, Nigeria, Peru, Portugal, Sri Lanka, Sweden, Tunisia, and Venezuela.3 Related topics such as the food safety and nutritional aspects of infant and young child feeding are also included regularly in the Digest.

206. WHO, with support from UNICEF, prepared an informal worldwide compilation of legislative texts and other relevant material, including codes of conduct, dealing with the marketing and labelling of infant foods and their quality standards. The compilation covers nearly 70 countries; certain directives of the European Community; materials emanating from the European Parliament and the Codex Alimentarius Commission; as well as various items developed by nongovernmental organizations and the infant-food industry. In addition to coverage in the Digest, where appropriate, this information is shared directly, on request, with responsible authorities in countries that are interested in profiting from an exchange of information on laws, regulations, and other measures concerning the marketing and distribution of infant foods, including breast-milk substitutes.

207. WHO and UNICEF have also assembled an informal, loose-leaf handbook with a view to providing lawyers, administrators, and other interested persons with background information and documentation relating to the development, adoption and implementation of the International Code and as a means of promoting a better understanding of the instrument and how individual countries might give effect to it in the light of national circumstances.

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1 In Afghanistan.
2 Resolution WHA33.32, paragraph 5(2).
3 See the specific references to these and other texts published in the Digest in the preceding paragraphs on each country.
Informal consultations concerning implementation of the International Code of Marketing of Breast-milk Substitutes

208. An informal consultation was held in Geneva in June 1982 with a group of international lawyers who, because of their familiarity with a broad range of countries and legal systems, were invited to consider different strategies for the implementation of the International Code. Participants inter alia formulated a "General framework for the development of national measures to give effect to the International Code of Marketing of Breast-milk Substitutes". The framework divides the Code into nine main components and posits a number of possible binding and non-binding actions (statutes, decrees, regulations, codes of ethics, voluntary agreements and guidelines) governments may take to give effect to each.

209. A similar informal gathering was organized in Copenhagen in November 1982 by the Regional Office for Europe, with participants from 11 Member States of the Region. It reviewed types of legal measures best suited for implementing various provisions of the International Code; ways and means of achieving a coordinated intersectoral approach to Code implementation and monitoring; the role of international and regional intergovernmental organizations; the role of nongovernmental organizations; and the feasibility of the development of model legislation for specific groups of countries. The seminar's report was issued under the title "Strategies for the legal implementation of the International Code of Marketing of Breast-milk Substitutes".

The Commonwealth

210. The Seventh Commonwealth Health Ministers' Meeting (Ottawa, 2-8 October 1983), dealing with medical-legal matters, put considerable emphasis on the implementation of the International Code. The Meeting recalled the origins of the Code and reviewed the status of adoption by member countries. In certain cases, even though the Code itself had not been adopted, measures had been taken to implement some of its features, such as the outright banning of advertising, the prevention of health institutions from accepting samples, or the requirement that feeding bottles be sold on prescription only.

211. The Meeting stressed the importance, for effective application, of the adoption of the Code by all countries, and of thus ensuring the quality of products marketed in conformity with the provisions of the Code. It recommended that countries which had not yet adopted the International Code should speed up their efforts to do so, and that the Commonwealth Secretariat commission a report on socio-medical and legal issues and their implications, with a view to establishing a Commonwealth mechanism for monitoring developments in this field, and to report to the meeting of member countries to be held prior to the World Health Assembly in 1984.

Commonwealth Secretariat/WHO/UNICEF interregional workshop

212. WHO co-sponsored, with the Commonwealth Secretariat and UNICEF, a workshop on the socio-medical and legal aspects of the implementation of the International Code of Marketing of Breast-milk Substitutes (see also paragraph 167). Ten Commonwealth member countries participated in this multisectoral discussion, held in Harare from 17 to 21 January 1983. In-depth national surveys, undertaken by two consultants, as well as reports presented by national representatives, provided the basis for the consensus of opinion that the International Code was serving to draw attention to the problems of infant and young child feeding. While the pace with which the Code itself was being taken up in countries may have been slower than originally hoped for, there had nevertheless been significant side benefits.

213. Many participants considered that, wherever appropriate, existing legislation should be used to give effect to the International Code in order to accelerate the process of implementation, in addition to the fact that existing administrative structures could be utilized to enforce its various provisions. Two examples of model legislation, for adaptation at the national level, were discussed and amended. As regards the scope of the International Code, a strong case was made by most of the African participants that it should

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2 Bangladesh, Kenya, Lesotho, Malaysia, Malawi, Papua New Guinea, Sri Lanka, Trinidad and Tobago, United Republic of Tanzania, and Zimbabwe, all of which are Member States of WHO.
be widened to include weaning foods since in the African Region it was at weaning that major problems of infant and young child malnutrition first manifested themselves. The report of the workshop was presented to the Commonwealth Law Ministers' Conference in February 1983.

Cooperation with all parties concerned in the implementation and monitoring of the International Code

214. In addition to supporting Member States, the Health Assembly requested the Director-General, in operative paragraph 5(2) of resolution WHA34.22, "to use his good offices for the continued cooperation with all parties concerned in the implementation and monitoring of the International Code at country, regional and global levels".

215. Accordingly, WHO has remained in close contact with professional groups, institutions, and individuals concerned, but especially with manufacturers and distributors of products that are within the scope of the Code, and nongovernmental organizations that have been active in promoting appropriate infant and young child feeding practices. Several individual manufacturers of infant formula, for example, in their efforts "to ensure that their conduct at every level conforms" to the principles and aim of the International Code (Article 11.3), have sought the Secretariat's views both on general marketing policies and on specific issues such as product labels (see paragraph 209 concerning the informal consultation held with manufacturers of infant formula in the European Region).

216. At the same time a number of nongovernmental organizations continue to keep WHO informed about their multiple activities to improve infant and young child nutrition, for example their sponsoring of regional and interregional conferences to promote breast-feeding and their support for national efforts to give effect to the International Code, in accordance with its Article 11.4.

NUTRITIONAL VALUE AND SAFETY OF PRODUCTS SPECIFICALLY INTENDED FOR INFANT AND YOUNG CHILD FEEDING

217. In accordance with Health Assembly resolutions WHA33.32 and WHA34.23, various steps have been taken to assess changes that occur with time under various climatic conditions, particularly in tropical countries, and under prevailing storage arrangements, in the quality, nutritional value and safety of products used specifically for infant and young child feeding.

218. These steps included the convening in October 1981 of an informal consultation for the purpose of reviewing existing information on the subject and suggesting additional possible information sources as well as elements to be included in the development of a protocol for laboratory studies; and a report prepared by a WHO consultant on conditions encountered in three countries with tropical or subtropical climates - India, the Philippines, and Trinidad and Tobago - during the period October 1982 to January 1983. A summary of the consultant's main findings was presented to the Health Assembly in May 1983,¹ and the complete report is now available.²

219. The Government of Switzerland has expressed interest in making a voluntary contribution to help finance the launching of laboratory studies in collaboration with appropriate national research institutions. Final arrangements are being made for this purpose. The product samples necessary for testing are being provided by the infant-food industry, which also participated in the October 1981 meeting, provided relevant information on the basis of a questionnaire sent to individual manufacturers of infant formula, and commented on the technical aspects of the planned laboratory studies.

220. In the African Region, in this connection, two consultants visited nine countries (Benin, Cameroon, Ethiopia, Kenya, Lesotho, Nigeria, Senegal, Sierra Leone, and Zaire) with a view to determining relevant areas of inquiry and methods applicable to the Region, taking into account the circumstances prevailing in each country and the relevant Codex Alimentarius requirements.

¹ See document A36/7, Part II.
² Document NUT/83.4.
CONCLUSION

221. Infant and young child nutrition and related subject areas, including the protection and promotion of breast-feeding, the promotion of appropriate weaning practices, and the nutrition and health of women, have been among WHO's major priorities since its inception.

222. The concept of health as a continuum - the accumulated legacy of maternal, infant, child and adolescent health - is gaining acceptance internationally, and has contributed in recent years to greater awareness of the importance that nutritional status and child feeding have in the life of the individual. There is thus an increasing appreciation of the interaction between infant feeding mode, birth spacing, nutritional deficiencies, and women's health during pregnancy and delivery; birth weight and an infant's chances for survival and vulnerability to disease; and the way in which all these factors affect child, adolescent, and adult health.

223. Numerous resolutions adopted by the World Health Assembly and the regional committees over the years relating to maternal and child health, infant and young child feeding, and the development and implementation of national and international food and nutrition policies and plans, have repeatedly emphasized that widespread malnutrition is not only a serious problem in its own right, but is an impediment to the attainment of national and international socioeconomic goals. They have also recognized that availability of food, while important, is no guarantee against malnutrition, since malnutrition is influenced by a large number of health, environmental, and social factors.

224. The wide-ranging discussions that have taken place at recent regional committee sessions and at every World Health Assembly since 1980 on infant and young child feeding and nutrition, as well as the information summarized in reports by the Director-General (see paragraphs 49-51), are indicative of a broad and comprehensive approach to maternal and child health and nutrition. The unprecedented flow of information on action taken on the International Code of Marketing of Breast-milk Substitutes by some 130 countries and territories in all regions is evidence that the level of national and international awareness of the importance and interdependence of the related issues has increased since 1979. It also demonstrates conclusively that all Member States are giving effect to the International Code as part of their wider efforts to address the health and nutritional problems of infants and young children, and the health and social status of women and families.

225. These are encouraging developments which have occurred within a relatively brief period; five years after the 1979 WHO/UNICEF Meeting on Infant and Young Child Feeding\(^1\) it is possible to say with conviction that real progress in this area has been achieved, especially as regards heightened public awareness of the importance of appropriate nutrition during pregnancy and lactation, breast-feeding, and appropriate weaning. Obviously, awareness of a problem, while an indispensable condition for action, cannot serve as a substitute for it.

226. The development of national strategies for health for all, and the adoption of the primary health care approach to achieve them, are the key to success in this respect. They point the way and indicate the means to be used. Precisely because it is not exclusively a question of national strategies of governments, but of national strategies that depend on action by all groups in society, starting with the family and community, and because primary health care is essential care made accessible to individuals and families in the community through their participation, the best immediate hope for attaining the needed improvements in the health and nutritional status of women, infants, and young children lies in the rapid and full realization of national strategies in all countries.

227. WHO, through its overall programme of nutrition in primary health care, continues to support national efforts to reduce and eliminate the five major nutritional deficiencies - in protein, energy, iron, iodine, and vitamin A - to which all of the most severe and widespread forms of malnutrition in the world today are related. Its approach to the problem is based inter alia on promoting awareness of the prevalence of these deficiencies and their effects on health; providing technical support to countries for the implementation of existing technologies; and developing improved methods of prevention, detection and control. This report is intended to contribute to that approach by highlighting selected global and regional nutritional status trends, as well as some of the practical steps that are being taken to deal with the multiple factors that are responsible for malnutrition among vulnerable groups.

\(^1\) See document WHA33/1980/REC/1, Annex 6.
MEMBERSHIP OF THE HEALTH ASSEMBLY

LIST OF DELEGATES AND OTHER PARTICIPANTS

DELEGATIONS OF MEMBER STATES

AFGHANISTAN

Delegates

Dr N. KAMYAR, Minister of Public Health
(Chief Delegate)

Dr W. A. KHERAD, Chargé d'affaires,

Professor M.-M. EJAZI, President, Medical Institute of Kabul, Ministry of Public Health

Alternates

Professor A. BENADOUDE, Officer responsible for Studies and Syntheses, Ministry of Public Health

Professor D. MAMMERI, Officer responsible for Studies and Syntheses and for Relations with WHO, Ministry of Public Health

Professor M. M. BENHASSINE, Director-General of the Pasteur Institute, Algiers

Mr M. I. MADANY, Director of External Relations, Ministry of Public Health

Mr A. AOUN-SEGHIR, Chancellor, Ministry of Foreign Affairs


Dr A. DJEFFAL, Director-General, Beni-Mellal University Hospital

ALBANIA

Delegates

Professor A. ALUSHANI, Minister of Public Health (Chief Delegate)

Professor V. ZOGU, Dean, Faculty of Medicine, University of Tirana (Deputy Chief Delegate)

Mr K. HYSENAJ, Counsellor, Embassy of the People's Socialist Republic of Albania in France

Alternate

Dr K. HAXHI, Ministry of Public Health

ALGERIA

Delegates

Mr D. E. HOUHOU, Minister of Public Health (Chief Delegate)

Mr S. OULD-ROUS, Ambassador, Permanent Representative of the Democratic People's Republic of Algeria to the United Nations Office and the Specialized Agencies at Geneva (Deputy Chief Delegate)

Mr B. SACI, Minister Plenipotentiary, Deputy Permanent Representative of the Democratic People's Republic of Algeria to the United Nations Office and the Specialized Agencies at Geneva

Alternates

Dr A. J. FERREIRA NETO, Minister of Health (Chief Delegate)

Dr A. PITRA, National Director of Endemic Diseases Control, Ministry of Health

Dr E. DOS SANTOS, Dean, Faculty of Medicine, Luanda

ANTIGUA AND BARBUDA

Delegates

Mr C. H. O'MARD, Minister of Health (Chief Delegate)

Dr A. I. BOYD, Chief Medical Officer, Ministry of Health
ARGENTINA

Delegates
Dr A. C. NERI, Minister of Health and Social Affairs (Chief Delegate)
Dr A. C. PRIETO, Under-Secretary for Health Resources, Ministry of Health and Social Affairs
Dr L. H. VERÁ OCAMPO, Director of International Relations, Ministry of Health and Social Affairs

Alternates
Mr O. LÓPEZ NOGUEROL, Ambassador, Permanent Representative of the Republic of Argentina to the United Nations Office and the Other International Organizations at Geneva
Mr R. ALMENDRA, Senator in the National Assembly

Advisers
Mrs N. NASCIMBENE DE DUMONT, Second Secretary, Permanent Mission of the Republic of Argentina to the United Nations Office and the Other International Organizations at Geneva
Mr J. J. ARCURI, Second Secretary, Permanent Mission of the Republic of Argentina to the United Nations Office and the Other International Organizations at Geneva

AUSTRALIA

Delegates
Dr N. BLEWETT, Minister for Health (Chief Delegate)
Mr L. J. WILLETT, Director-General of Health, Department of Health
Mr D. M. SADLEIR, Ambassador, Permanent Representative of Australia to the United Nations Office and the Other International Organizations at Geneva

Alternates
Dr B. P. KEAN, Assistant Director-General, International Health and Tuberculosis Branch, Department of Health
Mr T. J. CLEARY, State Minister for Health, Minister for Community Welfare and the Elderly and Minister for Ethnic Affairs, Tasmania

Advisers
Mr J. M. SPARROW, Special Medical Adviser to the State Minister for Health, Tasmania

AUSTRIA

Delegates
Dr J. DAIMER, former Deputy Director-General of Public Health, Federal Ministry of Health and Environmental Protection (Chief Delegate)
Dr R. Havlash, Director-General, Legal Department, Federal Ministry of Health and Environmental Protection

Alternates
Dr G. Liebswar, Deputy Director-General of Public Health, Federal Ministry of Health and Environmental Protection
Professor V. H. Havlovíc, Director, Federal Ministry of Health and Environmental Protection
Dr Elfriede Fritz, Director, Federal Ministry of Health and Environmental Protection
Mr F. Trauttmansdorff, First Secretary, Permanent Mission of Austria to the United Nations Office and Specialized Agencies at Geneva

BAHAMAS

Delegates
Mr L. N. Coakley, Minister of Health (Chief Delegate)
Dr V. Allen, Chief Medical Officer, Ministry of Health (Deputy Chief Delegate)
Mrs V. F. Brown, Deputy Permanent Secretary, Ministry of Health
BAHRAIN

Delegates
Mr J. S. AL-ARRAYED, Minister of Health (Chief Delegate)
Mr K. AL-SHAKAR, Ambassador, Permanent Representative of the State of Bahrain to the United Nations Office and Specialized Agencies at Geneva (Deputy Chief Delegate)
Dr E. YACOUB, Assistant Under-Secretary for Preventive and Primary Health Care, Ministry of Health

Alternates
Mr F. Y. AL-HAMER, Dean, College of Health Sciences, Ministry of Health
Mr I. AKBARI, Head, International, Arab and Public Relations Office, Ministry of Health

BELGIUM

Delegates
Mr F. AERTS, Secretary of State for Public Health and the Environment (Chief Delegate)
Dr P. DE SCHOUWER, Secretary-General, Ministry of Public Health and Family Welfare (Deputy Chief Delegate)
Mr A. ONKELINX, Ambassador, Permanent Representative of Belgium to the United Nations Office and the Specialized Agencies at Geneva

Alternates
Mr R. DE WULF, Community Minister of Health Policy (Flemish Executive)
Dr E. MINTIENS, Attaché, Office of the Minister - Member of the Executive of the French Community
Mr A. BERWAERTS, Senior Inspector for International Relations, Ministry of Public Health and Family Welfare
Dr J. BURKE, Senior Physician, Director, General Administration of Cooperation for Development
Mrs C. FUNES-NOPPEN, First Secretary, Permanent Mission of Belgium to the United Nations Office and the Specialized Agencies at Geneva
Professor A. LAFOINTAINE, Honorary Director, Institute of Hygiene and Epidemiology, Brussels

Advisers
Mr D. SAUER, Chef de cabinet, Ministry of Public Health and Family Welfare
Professor J. CEULEERS, Chef de cabinet of the Community Minister of Health Policy (Flemish Executive)
Mr G. LEENEN, Secretary, Office of the Secretary of State for Public Health and the Environment
Dr G. PEETERS, Chargé de mission, Office of the Flemish Community Minister for Health Policy
Mr J. BAES, Press Attaché, Office of the Minister for the Flemish Community
Professor R. BECKERS, Director-General, Public Health Administration, Ministry of Public Health and Family Welfare
Dr G. CLAUS, Director-General of Public Health, Ministry for the Flemish Community

1 On 10 May.
2 Chief Delegate from 7 to 9 May and from 11 May.
3 Deputy Chief Delegate from 7 to 9 May and from 11 May.

BANGLADESH

Delegates
Dr M. SHAMSUL HAQ, Minister of Health and Population Control (Chief Delegate)
Dr M. HEDAYETULLAH, Director General of Health Services, Ministry of Health and Population Control
Mr S. M. HOSSAIN, Counsellor, Permanent Mission of the People's Republic of Bangladesh to the United Nations Office and Other International Organizations at Geneva

Alternate
Mr L. A. CHOUDHURY, Second Secretary, Permanent Mission of the People's Republic of Bangladesh to the United Nations Office and Other International Organizations at Geneva

BARBADOS

Delegates
Mr O. TROTMAN, Minister of Health (Chief Delegate)
Dr B. MILLER, Acting Chief Medical Officer, Ministry of Health
Mrs J. TROTMAN, Secretary, Ministry of Health
Mr K. GUTSCHOVEN, Health Administration, Ministry for the Flemish Community
Professor F. BARO, Faculty of Medicine, Catholic University of Louvain
Mrs I. BORLÉE-GRIMÉE, School of Public Health, Catholic University of Louvain
Professor L. EYCKMANS, Director, Prince Leopold Institute of Tropical Medicine, Antwerp
Professor W. J. EYLENBOSCH, Section of Epidemiology and Social Medicine, University of Antwerp
Professor A. LAURENT, President, School of Public Health, Free University of Brussels
Dr Gilberte M. REGINSTER, Institute of Hygiene and Social Medicine, University of Liège
Professor A. DE SCHAEFPDRYVER, Vice-Dean, Faculty of Medicine, University of Ghent
Professor C. THILLY, School of Public Health, Free University of Brussels
Dr M. E. F. TORFS, School of Public Health, Catholic University of Louvain
Professor K. VUYLSTEKEK, Faculty of Medicine, University of Ghent
Mr J. ORENBUCH, Director, Centre for Study on Social Change, Institute of Sociology, Free University of Brussels
Mr L. D'AES, Second Secretary, Permanent Mission of Belgium to the United Nations Office and the Specialized Agencies at Geneva
Professor Anne-Marie DEPOORTER, Free University of Brussels (Flemish Section)
Dr Madeleine DECORTIS-CONSTANT, Director, Provincial Institute of Paramedical Higher Education, Liège
Mr J. CORDEIRO, Staff Training Officer

BENIN

Delegates
Mr P. AKPO, Minister of Public Health (Chief Delegate)
Dr F. DJROLO, Officer responsible for the Division of International Relations, Directorate of Studies and Planning, Ministry of Public Health
Dr L. MEDJ1, Vice-Dean, Faculty of Health Sciences, National University

BHUTAN

Delegates
Dr T. YOUNTAN, Director of Health Services (Chief Delegate)
Dr P. W. SAMDUP, Superintendent of Health Services

BOLIVIA

Delegates
Dr J. TORRES GOITIA, Minister of Social Welfare and Public Health (Chief Delegate)
Mr A. CRESPO, Ambassador, Permanent Representative of the Republic of Bolivia to the United Nations Office and the Other International Organizations at Geneva
Mrs A. C. LORENZ, Minister Counsellor, Permanent Mission of the Republic of Bolivia to the United Nations Office and the Other International Organizations at Geneva

Alternate
Mrs S. SALAZAR, Counsellor

BOTSWANA

Delegates
Mr L. H. MAKGEKGHENENE, Minister of Health (Chief Delegate)
Dr D. B. SEBINA, Permanent Secretary for Health (Deputy Chief Delegate)
Dr E. T. MAGANU, Principal Medical Officer of Health, Ministry of Health

Alternate
Mrs K. M. MAKHWADE, Director of Nursing Services, Ministry of Health

BRAZIL

Delegates
Dr W. MENDES ARCOVERDE, Minister of Health (Chief Delegate)
Dr G. M. BONOW, Secretary for Health and Environment, State of Rio Grande do Sul (Deputy Chief Delegate)
Mrs V. RUMJANEK CHAVES, Coordinator of International Affairs, Ministry of Health

Alternates
Mr F. CUMPLIDO, Minister for Commercial Affairs, Permanent Mission of Brazil to the United Nations Office and the Other International Organizations at Geneva
Mr G. VERGNE SABOIA, Counsellor, Permanent Mission of Brazil to the United Nations Office and the Other International Organizations at Geneva
Mr C. DE MELO, Secretary, Permanent Mission of Brazil to the United Nations Office and the Other International Organizations at Geneva
Mr E. A. CASCIANO, Secretary, Ministry for External Relations
### BULGARIA

**Delegates**
- Professor R. POPIVANOV, Minister of Public Health (Chief Delegate)
- Dr M. MILEV, Vice-Minister of Public Health
- Professor I. NICOLOV, Director, Scientific Institute of Radiology and Radiobiology

**Advisers**
- Dr N. VASSILEVSKI, Director, Department of International Relations, Ministry of Public Health
- Dr Stefanka BATCHWAROVA, Senior Medical Officer, Ministry of Public Health
- Dr L. IVANOV, Institute of Social Medicine
- Mr S. STEFANOV, Economics Department, Ministry of Foreign Affairs
- Mr K. PRAMOV, Third Secretary, Permanent Mission of the People's Republic of Bulgaria to the United Nations Office and the Other International Organizations at Geneva

### BURMA

**Delegates**
- Mr TUN WAI, Minister of Health (Chief Delegate)
- Mr MAUNG MAUNG GYI, Ambassador, Permanent Representative of the Socialist Republic of the Union of Burma to the United Nations Office and Other International Organizations at Geneva (Deputy Chief Delegate)
- Dr PE THEIN, Director-General, Department of Health, Ministry of Health

**Alternates**
- Dr TIN OO, Director-General, Department of Medical Education, Ministry of Health
- Dr TIN AUNG SWE, Rector, Institute of Medicine II, Rangoon
- Dr THEIN DAN, Deputy Director (Training), Department of Health, Ministry of Health
- Mr TIN NYUNT, Personal Assistant to the Minister of Health

### BURUNDI

**Delegates**
- Dr F. NSABIMANA, Minister of Public Health (Chief Delegate)
- Mr T. NSANZE, Ambassador, Permanent Representative of the Republic of Burundi to the United Nations Office and the Specialized Agencies at Geneva (Deputy Chief Delegate)
- Dr P. MPITABAKANA, Director-General of Public Health

**Alternates**

### CAMEROON

**Delegates**
- Professor V. A. NGU, Minister of Public Health (Chief Delegate)
- Mr D. YONG, Deputy Permanent Representative of the Republic of Cameroon to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
- Dr S. ATANGANA, First Technical Adviser, Ministry of Public Health

**Alternates**
- Dr F. C. MAFIAMBA, Director of Preventive Medicine and Public Hygiene, Ministry of Public Health
- Dr Gladys MARTIN, Senior Lecturer, University Centre for Health Sciences

### CANADA

**Delegates**
- Mrs M. BÉGIN, Minister of National Health and Welfare (Chief Delegate), replaced from 10 May by:
  - Mr R. MACLELLAN, Deputy and Parliamentary Secretary
  - Mr J. A. BEESLEY, Ambassador, Permanent Representative of Canada to the United Nations Office and the Other International Organizations at Geneva
- Dr Maureen M. LAW, Associate Deputy Minister, Department of National Health and Welfare

**Alternates**
- Mr F. TANGUY, Minister Counsellor, Deputy Permanent Representative of Canada to the United Nations Office and the Other International Organizations at Geneva
- Dr B. HALLIDAY, Member of Parliament
- Mr R. EDWARDS, Deputy Minister of Health, Province of Manitoba
- Mr R. DE BURGER, Assistant Deputy Minister of Health, Preventive Services, Department of Health, Province of British Colombia
### Advisers

- **Dr. C. W. L. JEANES**, Chief, Health and Population Division, Canadian International Development Agency  
- **Mrs. M. STOUT**, Adviser to the Minister of National Health and Welfare  
- **Dr. J. R. LARIVIÈRE**, Senior Medical Adviser, Intergovernmental and International Affairs, Department of National Health and Welfare  
- **Mrs. J. CARON**, United Nations Affairs Division, Department of External Affairs  
- **Dr. G. RIVARD**, Associate Deputy Minister, Health Services, Department of Social Affairs, Province of Quebec  
- **Dr. G. HURTEAU**, Dean, Faculty of Health Sciences, University of Ottawa  
- **Mr. R. J. ROCHE**, Counsellor, Permanent Mission of Canada to the United Nations Office and the Other International Organizations at Geneva  
- **Mrs. M. L. CÔTÉ**, Adviser to the Minister of National Health and Welfare  

### CAPE VERDE

- **Delegates**  
  - **Dr. I. P. BRITO GOMES**, Minister of Health and Social Affairs (Chief Delegate)  
  - **Dr. J. DE D. LISBOA RAMOS**, Secretary General, Ministry of Health and Social Affairs  
  - **Dr. D. L. R. DANTAS DOS REIS**, Chief of Clinic, Agostinho Neto Hospital, Praia  

### CENTRAL AFRICAN REPUBLIC

- **Delegates**  
  - **Mr. X.-S. YANGONGO**, Minister of Public Health and Social Affairs (Chief Delegate)  
  - **Mr. N. KOMBOT-NAGEMON**, Ambassador, Permanent Representative of the Central African Republic to the United Nations Office at Geneva and the Specialized Agencies in Switzerland (Deputy Chief Delegate)  
  - **Dr. S. FEIKOUN MOND**, Secretary-General of Public Health, Ministry of Public Health and Social Affairs  

### CHAD

- **Delegates**  
  - **Dr. W. H. AMOULA**, Director of Public Health, Ministry of Public Health (Chief Delegate)  
  - **Mr. O. D. KHAYAR**, Secretary-General, University of Chad  

### CHILE

- **Delegates**  
  - **Mr. W. CHINCHON**, Minister of Public Health (Chief Delegate)  
  - **Dr. J. M. BORGONE**, Head, Office of International Affairs, Ministry of Public Health  
  - **Mr. J. BUSTOS**, Minister Counsellor, Deputy Permanent Representative of Chile to the United Nations Office at Geneva and the Other International Organizations in Switzerland  
  - **Alternates**  
    - **Mr. F. PÉREZ**, Counsellor, Permanent Mission of Chile to the United Nations Office at Geneva and the Other International Organizations in Switzerland  
    - **Mr. P. BARROS**, First Secretary, Permanent Mission of Chile to the United Nations Office at Geneva and the Other International Organizations in Switzerland  

### CHINA

- **Delegates**  
  - **Mr. TAN Yunhe**, Deputy Minister of Public Health (Chief Delegate)  
  - **Dr. XU Shouren**, Director, Bureau of Foreign Affairs, Ministry of Public Health  
  - **Mr. ZHI Jumbo**, Deputy Director, General Office, Ministry of Public Health  
  - **Alternates**  
    - **Mr. TIAN Sui**, Chief, Division of Post-Graduate Training for Medical Sciences and Education, Ministry of Public Health  
    - **Mr. SONG Lianzhong**, Chief, Division of Planning and Finance, Ministry of Public Health  
    - **Mrs. ZHEN Yun**, First Secretary, Department of International Organizations, Ministry of Foreign Affairs  
    - **Mr. CAO Yonglin**, Deputy Chief, Division of International Organizations, Bureau of Foreign Affairs, Ministry of Public Health  
    - **Mrs. CHEN Haihua**, Second Secretary, Permanent Mission of the People's Republic of China to the United Nations Office at Geneva and the Other International Organizations in Switzerland  

### THIRTY-SEVENTH WORLD HEALTH ASSEMBLY

- **Advisers**  
  - **Professor MAO Shoubai**, Director, Institute of Parasitical Diseases at Shanghai  
  - **Mr. QUAN Zhengfu**, Deputy Chief, Division of Technical Cooperation, Bureau of Foreign Affairs, Ministry of Public Health
MEMBERSHIP OF THE HEALTH ASSEMBLY

Mr DING Xiaoming, Liaison Division, Bureau of Foreign Affairs, Ministry of Public Health

COLOMBIA

Delegates
Dr J. ARIAS RAMIREZ, Minister of Health (Chief Delegate)
Mr H. CHARRY SAMPER, Ambassador, Deputy Permanent Representative of Colombia to the United Nations Office and the Specialized Agencies at Geneva (Deputy Chief Delegate)
Professor J. E. OSPINA, Director, National Cancer Institute

Alternates
Professor F. SÁNCHEZ-TORRES, Rector, National University
Mr C. AREVALO YEPES, Third Secretary, Permanent Mission of Colombia to the United Nations Office and the Specialized Agencies at Geneva

COMOROS

Delegates
Mr M. MOUMINI, Minister of Public Health and Populations (Chief Delegate)
Dr A. ZAÏDOU, Director of Basic Health Services

CONGO

Delegates
Mr P.D. BOUSSOUKOU-BOUMBA, Minister of Health and Social Affairs (Chief Delegate)
Mrs H. KINIONGONO, Director of Social Affairs, Ministry of Health and Social Affairs
Mr E. MBALOULA, Director of Studies and Planning, Ministry of Health and Social Affairs

Alternates
Mr J.-F. OPA, Director, National Public Health Laboratory, Ministry of Health and Social Affairs
Dr K. KINZOUNZA, Director, National School of Management and Magistrature, Brazzaville

COOK ISLANDS¹

Delegates
Mr T. SIMONA, Minister of Health and Agriculture (Chief Delegate)
Dr G. KOTEXA, Secretary of Health, Ministry of Health

COSTA RICA

Delegates
Dr J. JARAMILLO, Minister of Health (Chief Delegate)
Mr E. SOLEY SOLER, Ambassador, Permanent Representative of the Republic of Costa Rica to the United Nations Office and the Other International Organizations at Geneva
Dr O. ALFARO, Director-General of Health, Ministry of Health

Alternates
Dr G. WOLIO, Executive President, Joint Social Aid Institute
Mr L. C. DELGADO, Minister Counsellor, Permanent Mission of the Republic of Costa Rica to the United Nations Office and the Other International Organizations at Geneva

CUBA

Delegates
Professor J. M. DIEGO COBELO, Vice-Minister of Public Health (Chief Delegate)
Mr C. LECHUGA HEVIA, Ambassador, Permanent Representative of the Republic of Cuba to the United Nations Office at Geneva and the Other International Organizations in Switzerland
Professor J. R. MENCHACA MONTANO, Director of International Relations, Ministry of Public Health

¹ Cook Islands became a Member of WHO on depositing a formal instrument of acceptance of the Constitution with the Secretary-General of the United Nations on 9 May 1984 (see resolution WHA37.1).
Alternates
Mrs J. T. GARCÍA LORENZO, Head of department, Ministry of External Relations
Dr G. MONTALVO, Head, Department of International Organizations, Ministry of Public Health
Mrs A. M. LUETTCGEN DE LECHUGA, Second Secretary, Permanent Mission of the Republic of Cuba to the United Nations Office at Geneva and the Other International Organizations in Switzerland
Mrs A. I. OTERO, Directorate of International Organizations, Ministry of External Relations

Advisers
Dr J. P. GARCÍA SILVA, Adviser, Ministry of Public Health
Professor C. ORDOMÉZ CARCELLER, Ministry of Public Health

Delegates
Dr C. PELEGANOS, Minister of Health (Chief Delegate)
Mr A. NICOLAIDES, Ambassador, Permanent Representative of Cyprus to the United Nations Office at Geneva and Specialized Agencies in Switzerland (Deputy Chief Delegate)
Dr A. MARKIDES, Director of Medical and Public Health Services, Ministry of Health

Alternates
Mr E. KROLOS, Director of Pharmaceutical Services, Ministry of Health
Mr A. PIRISHIS, Counsellor, Deputy Permanent Representative of Cyprus to the United Nations Office at Geneva and Specialized Agencies in Switzerland

CZECHOSLOVAKIA

Delegates
Professor J. PROKOPEC, Minister of Health of the Czech Socialist Republic (Chief Delegate)
Professor E. MATEJÍČEK, Minister of Health of the Slovak Socialist Republic (Deputy Chief Delegate)
Dr Eliška KLIVAROVA, Director, Foreign Relations Department, Ministry of Health of the Czech Socialist Republic

Alternates
Dr K. GECÍK, Director, Secretariat of the Ministry of Health of the Slovak Socialist Republic
Mr J. BRATKO, Federal Ministry of Foreign Affairs
Mr J. JIRUŠEK, Third Secretary, Permanent Mission of the Czechoslovak Socialist Republic to the United Nations Office and the Other International Organizations at Geneva

DEMOCRATIC KAMPUCHEA

Delegates
Professor THIOUENN THOEUN, Minister of Health (Chief Delegate)
Professor CHHAY HAN CHENG, Ministry of Health (Deputy Chief Delegate)
Mr KHEK SYSODA, Ambassador

Alternates
Mr NGO HAC TEAM, Ambassador, Permanent Representative of Democratic Kampuchea to the United Nations Office at Geneva and the Other International Organizations in Switzerland
Dr YO ENG HORN
Dr OUM NAL
Mrs THIOUENN MALATEVI, Ministry of Health
Dr THACH KIM SUA
Mrs POC MONA, First Secretary, Permanent Delegation of Democratic Kampuchea to the United Nations Office at Geneva and the Other International Organizations in Switzerland
Mr VAR LOEUNG
Mr TEP DARONG

DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

Delegates
Dr KIM Yong Ik, Vice-Minister of Public Health (Chief Delegate)
Mr SIN Hyon Rim, Minister, Deputy Permanent Observer of the Democratic People's Republic of Korea to the United Nations Office and Deputy Permanent Delegate to the Other International Organizations at Geneva
Dr KIM Won Ho, Chief of section, Research Institute of Health Organization, Ministry of Public Health

Alternates
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

1 Chief Delegate from 14 May.
MEMBERSHIP OF THE HEALTH ASSEMBLY

DEMOCRATIC YEMEN

Delegates
Mrs. S. FARES, Minister Plenipotentiary, Permanent Mission of the People's Democratic Republic of Yemen to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

DENMARK

Delegates
Dr. S. K. SØRENSEN, Director-General, National Board of Health (Chief Delegate)
Mr. G. A. LUSTRUP, Deputy Permanent Secretary, Ministry of the Interior
Dr. N. ROSDAHL, Deputy Director-General, National Board of Health

Alternates
Mrs. E. LUND, Head of division, Ministry of the Interior
Mr. E. FIIL, Head of division, Ministry of Foreign Affairs
Mr. J. MOLDE, First Secretary, Permanent Mission of Denmark to the United Nations Office and the Other International Organizations at Geneva
Miss I. M. MADSEN, Chief Nursing Officer, National Board of Health
Dr. C. LUNDSTEDT, Senior Medical Officer of Health, National Board of Health
Mr. J. JØRGENSEN, Head of section, Ministry of the Interior
Miss M. K. NIELSEN, Head of section, Ministry of Foreign Affairs

Advisers
Mr. K. REPSDORPH, Ambassador, Permanent Representative of Denmark to the United Nations Office and the Other International Organizations at Geneva
Dr. J. C. SIIM, Director, State Serum Institute, Copenhagen
Mr. J. TØRNING, Director, State Serum Institute, Copenhagen

EGYPT

Delegates
Mr. M. S. ZAKI, Minister of Health (Chief Delegate)
Mr. S. AL FARARGUI, Ambassador, Permanent Representative of the Arab Republic of Egypt to the United Nations Office and the Specialized Agencies at Geneva (Deputy Chief Delegate)
Dr. A. A. EL GAMAL, Head, Section of Preventive Medical Affairs, Ministry of Health

Alternates
Dr. I. BASSIOUNI, Director, Central Department for Development and Research, Ministry of Health

DOMINICAN REPUBLIC

Delegates
Dr. T. MEJÍA-RICART, Ambassador, Permanent Representative of the Dominican Republic to the United Nations Office and the Other International Organizations at Geneva (Chief Delegate)
Mrs. M. ALFONSECA BURSZTEJN-LAVIGNE, Minister Counsellor, Permanent Mission of the Dominican Republic to the United Nations Office and the Other International Organizations at Geneva
Mrs. A. BONETTI HERRERA, First Secretary, Permanent Mission of the Dominican Republic to the United Nations Office and the Other International Organizations at Geneva

ECUADOR

Delegates
Dr. L. SARRAZÍN, Minister of Public Health (Chief Delegate)
Dr. C. TRONCOSO, Technical Director, Subsecretariat for Health, Ministry of Public Health (Deputy Chief Delegate)
Dr. E. RODRÍGUEZ, Director of International Relations, Ministry of Public Health

DJIBOUTI

Delegates
Mr. M. ADABO KAKO, Minister of Public Health and Social Affairs (Chief Delegate)
Dr. A. E. ADOU, National Coordinator of Primary Health Care, Ministry of Public Health

DOMINICAN REPUBLIC

Delegates
Dr. T. MEJÍA-RICART, Ambassador, Permanent Representative of the Dominican Republic to the United Nations Office and the Other International Organizations at Geneva (Chief Delegate)
Mrs. M. ALFONSECA BURSZTEJN-LAVIGNE, Minister Counsellor, Permanent Mission of the Dominican Republic to the United Nations Office and the Other International Organizations at Geneva
Mrs. A. BONETTI HERRERA, First Secretary, Permanent Mission of the Dominican Republic to the United Nations Office and the Other International Organizations at Geneva

ECUADOR

Delegates
Dr. L. SARRAZÍN, Minister of Public Health (Chief Delegate)
Dr. C. TRONCOSO, Technical Director, Subsecretariat for Health, Ministry of Public Health (Deputy Chief Delegate)
Dr. E. RODRÍGUEZ, Director of International Relations, Ministry of Public Health

EGYPT

Delegates
Mr. M. S. ZAKI, Minister of Health (Chief Delegate)
Mr. S. AL FARARGUI, Ambassador, Permanent Representative of the Arab Republic of Egypt to the United Nations Office and the Specialized Agencies at Geneva (Deputy Chief Delegate)
Dr. A. A. EL GAMAL, Head, Section of Preventive Medical Affairs, Ministry of Health

Alternates
Dr. I. BASSIOUNI, Director, Central Department for Development and Research, Ministry of Health

1 Chief Delegate from 12 May.
Dr H. S. HELMY, Director, General
Department of Medical External
Relations, Ministry of Health
Dr H. EL BERMAYW, Director, General
Department of Planning Affairs,
Ministry of Health
Dr H. AMER, Director-General, Department
of Prevention of Epidemic Diseases,
Ministry of Health

Advisers
Mr M. BADR, Counsellor, Permanent Mission
of the Arab Republic of Egypt to the
United Nations Office and the
Specialized Agencies at Geneva
Mr I. A. HASSAN, Counsellor, Permanent
Mission of the Arab Republic of Egypt
to the United Nations Office and the
Specialized Agencies at Geneva
Miss W. BASSIM, Second Secretary,
Permanent Mission of the Arab Republic
of Egypt to the United Nations Office
and the Specialized Agencies at Geneva
Mr A. HELMY, Third Secretary, Permanent
Mission of the Arab Republic of Egypt
to the United Nations Office and the
Specialized Agencies at Geneva

EL SALVADOR

Delegates
Dr N. E. CÁRDENAS, Minister of Public
Health and Social Affairs (Chief Delegate)
Dr A. GONZALEZ, Ambassador, Deputy
Permanent Representative of the
Republic of El Salvador to the United
Nations Office and the Other
International Organizations at Geneva
Dr J. G. TRABANINO, Advisory Council on
External Relations, Ministry of Public
Health and Social Affairs

Alternates
Dr R. R. HUEZO MELARA, Minister
Counsellor, Deputy Permanent
Representative of the Republic of
El Salvador to the United Nations
Office and the Other International
Organizations at Geneva
Mr C. A. BARAHONA, First Secretary,
Permanent Mission of the Republic of
El Salvador to the United Nations
Office and the Other International
Organizations at Geneva

EQUATORIAL GUINEA

Delegate
Dr D. V. NSUE MILANG, Director-General
of Hospital Coordination, Ministry of Health

ETHIOPIA

Delegates
Dr G. TSEHAY, Minister of Health
(Chief Delegate)
Mr G.-E. TEKA, Head, Planning and
Programming Bureau, Ministry of Health
(Deputy Chief Delegate)¹
Dr ZEIN AHMED, Deputy Dean and Assistant
Professor, Medical Sciences College,
Gondar, Addis Ababa University

Alternate
Mr K. SHENKORU, Second Secretary,
Permanent Mission of Ethiopia to the
United Nations Office at Geneva

FIJI

Delegate
Dr T. M. BIUMAIWAI, Permanent
Secretary for Health and Social Welfare

FINLAND

Delegates
Dr Eeva KUUSKOSKI-VIKATMAA, Minister of
Social Affairs and Health (Chief Delegate)
Dr H. RUOKOLA, Director-General, National
Board of Health (Deputy Chief Delegate)²
Dr K. LEFFO, Director, Department of
Planning and Evaluation, National Board of Health

Alternates
Dr M. MURTOMAA, Acting Director,
Department of Hygiene and Health
Promotion, National Board of Health
Mr R. KÄRKKÄINEN, Government Counsellor,
Ministry of Social Affairs and Health
Mrs L. OLLILA, Secretary for International
Affairs, Ministry of Social Affairs and Health
Mrs T. RAIVIO, First Secretary, Permanent
Mission of Finland to the United
 Nations Office and the Other
International Organizations at Geneva
Mrs P. LUOSTARINEN, Attaché, Ministry for
Foreign Affairs
Mr A. MYKKÄNEN, Political Secretary to the
Minister of Social Affairs and Health

¹ Chief Delegate from 14 May.
² Chief Delegate from 10 May.
### France

**Delegates**
- Mr. E. Hervé, Secretary of State for Health (Chief Delegate)
- Professor J. Roux, Director-General of Health, Secretariat of State for Health
- Mr. M. Brochard, Counsellor for Foreign Affairs, Ministry of External Relations

**Alternates**
- Miss P. Debev, Chargé de mission, Ministry of External Relations (Cooperation and Development Service, Policies Directorate)
- Mrs. J. T. de la Batut, Chargé de mission, Ministry of External Relations (Directorate of United Nations and International Organizations Affairs)
- Dr. B. Flouri, Chargé de mission, Ministry of External Relations (Subdirectorate for Health and Social Affairs, Cooperation and Development Service)
- Mr. J.-P. Davin, Chargé de mission, Ministry of Social Affairs and National Solidarity (Division of International Relations)
- Dr. C. Martin-Bouyer, Technical Counsellor, Directorate-General of Health, Secretariat of State for Health
- Professor J. Monnier, University of Toulouse

**Advisers**
- Mr. J. Dangoumau, Director of Pharmacy and Drugs, Secretariat of State for Health
- Mr. J.-M. Momal, Second Counsellor, Permanent Mission of France to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
- Mr. J.-D. Leroy, Head, Division of International Relations, Ministry of Social Affairs and National Solidarity
- Professor M. Attissso, Chief Pharmacist, Montpellier Regional Hospital
- Professor R. Senault, Department of Hygiene and Social Medicine, Faculty of Medicine, Nancy
- Professor M. Gentilini, Faculty of Medicine, Pitié-Salpêtrière, Paris
- Mr. J.-P. Picard, Director, National School of Public Health, Rennes
- Dr. M. Brodin, International Centre for Social Development and Community Medicine, Bordeaux

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1. On 9 and 10 May.
2. Chief Delegate on 7, 8 and from 11 May.

### Gabon

**Delegates**
- Dr. J.-P. Okiias, Minister of Public Health and Population (Chief Delegate)
- Dr. L. Adande Menest, Inspector-General of Public Health, Ministry of Public Health and Population (Deputy Chief Delegate)
- Mr. M. Bouumba, Director General of Public Health, Ministry of Public Health and Population

**Alternates**
- Mr. J. R. Odzaga, Ambassador, Permanent Representative of the Gabonese Republic to the United Nations Office and the Other International Organizations at Geneva
- Mr. F. M'Bondoukwé, Director of the National Supply Pharmacy, Inspector of Pharmacies

**Advisers**
- Dr. A. Mbumbe-King, Head of section, Owendo Paediatric Hospital
- Mr. D. Akerey Rassaguiza, Adviser to the Minister of Public Health and Population
- Dr. B. N'Nang, Adviser to the Minister of Public Health and Population
- Dr. B. Obiang Ossoubita, Inspector-General of Labour Medicine, Ministry of Labour and Employment
- Mr. J.-B. Ngonang, Attaché, Office of the Minister of Public Health and Population
- Mr. T. Moussouda, First Counsellor, Permanent Mission of the Gabonese Republic to the United Nations Office and the Other International Organizations at Geneva
- Mr. M. Nze Ekom, Second Counsellor, Permanent Mission of the Gabonese Republic to the United Nations Office and the Other International Organizations at Geneva
Mr F. ITOUNBA, Second Counsellor, Permanent Mission of the Gabonese Republic to the United Nations Office and the Other International Organizations at Geneva

GAMBIA

Delegates
Mr M. G. JALLOW, Minister of Health, Labour and Social Welfare (Chief Delegate)
Mr S. A. NJAI, Permanent Secretary, Ministry of Health, Labour and Social Welfare
Dr A. B. H. NJIE, Assistant Director of Medical Services, Ministry of Health, Labour and Social Welfare

GERMAN DEMOCRATIC REPUBLIC

Delegates
Professor L. MECKLINGER, Minister of Health (Chief Delegate)
Dr R. MÜLLER, Deputy Minister of Health (Deputy Chief Delegate)¹
Dr K.-H. LEBENTRAU, Head of division, Department of International Relations, Ministry of Health

Alternates
Mr H. HASCHKE, Counsellor, Deputy Permanent Representative of the German Democratic Republic to the United Nations Office and the Other International Organizations at Geneva
Professor F. RENGER, Emeritus Director, "Theodor Brugsch" Medical Clinic, Humboldt University, Berlin
Mr F. WEGMARSHAUS, Deputy Head of division, Department of International Relations, Ministry of Health
Mrs G. WOLF, Second Secretary, International Economic Organizations Division, Ministry of Foreign Affairs
Dr H. BRÄMER, Scientific Adviser, Permanent Mission of the German Democratic Republic to the United Nations Office and the Other International Organizations at Geneva
Mrs K. ADAMCZYK, Scientific Adviser, Centre for WHO Affairs, Ministry of Health

¹ Chief Delegate from 15 May.

GERMANY, FEDERAL REPUBLIC OF

Delegates
Mr W. CHORY, Secretary of State, Federal Ministry for Youth, Family Affairs and Health (Chief Delegate)
Dr H. ARNOLD, Ambassador, Permanent Representative of the Federal Republic of Germany to the United Nations Office and the Other International Organizations at Geneva (Deputy Chief Delegate)²
Mr H. VOIGTLANDER, Director of International Health Relations, Federal Ministry for Youth, Family Affairs and Health

Alternates
Mr J. WEITZEL, Deputy Director of International Health Relations, Federal Ministry for Youth, Family Affairs and Health
Dr Ruth MATTHEIS, Director, Public Health Department, Berlin (West)
Mr G. BLAUROCK, Counsellor, Permanent Mission of the Federal Republic of Germany to the United Nations Office and the Other International Organizations at Geneva
Dr Christine GAUDICH, Head, Pharmaceutical Section, Federal Ministry for Youth, Family Affairs and Health
Mr B. ZIESE, Counsellor, Permanent Mission of the Federal Republic of Germany to the United Nations Office and the Other International Organizations at Geneva

Advisers
Dr R. KORTE, Head, Department of Health, Nutrition and Population, German Agency for Technical Cooperation (GTZ)
Professor T. FLIEDNER, University of Ulm

GHANA

Delegates
Mr E. G. TANOH, Secretary for Health, Ministry of Health (Chief Delegate)
Mr S. E. QUARM, Ambassador, Permanent Representative of the Republic of Ghana to the United Nations Office at Geneva and the Specialized Agencies in Switzerland (Deputy Chief Delegate)
Dr Y. ABOAGYE-ATTA, Director of Medical Services, Ministry of Health

Alternate
Dr K. WARD-BREW, Director of International Health Cooperation, Ministry of Health

² Chief Delegate from 11 May.
<table>
<thead>
<tr>
<th>Adviser</th>
<th>GUINEA</th>
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<tr>
<td>Mr L. K. CHRISTIAN, First Secretary, Permanent Mission of the Republic of Ghana to the United Nations Office at Geneva and the Specialized Agencies in Switzerland</td>
<td>Delegates</td>
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<td>Professor M. K. BAH, Minister of Health (Chief Delegate)</td>
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<td></td>
<td>Dr M. SYLLA, Deputy Chief Physician, Donka University Hospital Centre</td>
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<td>Dr M. CONTE, Regional Director of Health, Coyah, Ministry of Health</td>
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<td>Delegates</td>
<td>GUINEA-BISSAU</td>
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<tr>
<td>Mr I. FLOROS, Secretary of State, Ministry of Health and Social Welfare (Chief Delegate)</td>
<td>Delegates</td>
</tr>
<tr>
<td>Professor J. PAPAVASSILIOU, President, Central Health Council (Deputy Chief Delegate)</td>
<td>Dr P. C. DE MEDINA, Secretary-General, Ministry of Health and Social Affairs (Chief Delegate)</td>
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<tr>
<td>Mr A. PETROPOULOS, Ambassador, Permanent Representative of Greece to the United Nations Office at Geneva and the Specialized Agencies in Switzerland</td>
<td>Dr P. J. ALVES, Director, National Hospital (Deputy Chief Delegate)</td>
</tr>
<tr>
<td>Alternates</td>
<td>Dr J. C. GONÇALVES, Ministry of Health and Social Affairs</td>
</tr>
<tr>
<td>Dr K. SFANGOS, Vice-President, Central Health Council</td>
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<td>Dr A. PHILALITHIS, Member of the Executive Committee, Central Health Council</td>
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<tr>
<td>Mrs J. PANOPOLOU, Member of the Executive Committee, Central Health Council</td>
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<tr>
<td>Dr M. POTHOS, Director, Division of Public and International Relations, Ministry of Health and Social Welfare</td>
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<tr>
<td>Mr C. IVRAKIS, First Counsellor, Deputy Permanent Representative of Greece to the United Nations Office at Geneva and the Specialized Agencies in Switzerland</td>
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<tr>
<td>Advisers</td>
<td>GUYANA</td>
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<tr>
<td>Professor D. TRICHOPOULOS, Director, Department of Hygiene and Epidemiology, University of Athens</td>
<td>Delegates</td>
</tr>
<tr>
<td>Mr S. BEYS-KAMNAROKOS, Counsellor (Press), Permanent Mission of Greece to the United Nations Office at Geneva and the Specialized Agencies in Switzerland</td>
<td>Mr C. B. PHILADELPHIA, Permanent Secretary, Ministry of Health and Public Welfare (Chief Delegate)</td>
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<tr>
<td>Mr M. DELONAKIS, Counsellor</td>
<td>Dr Enid DENBOW, Principal Surgeon, Ministry of Health and Public Welfare</td>
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<td>GUATEMALA</td>
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<tr>
<td>Dr R. RIVERA ÁLVAREZ, Minister of Public Health and Social Welfare (Chief Delegate)</td>
<td>Dr R. GERMAIN, Minister of Public Health and Population (Chief Delegate)</td>
</tr>
<tr>
<td>Mrs N. CONTRERAS-SARAVIA, Minister Counsellor, Permanent Mission of Guatemala to the United Nations Office and the Specialized Agencies at Geneva</td>
<td>Dr V. PEAN, Chief, State University Hospital Laboratories</td>
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<td>HONDURAS</td>
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<td>Delegates</td>
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<tr>
<td>Dr R. LOPEZ LAGOS, Vice-Minister of Public Health (Chief Delegate)</td>
<td>Delegates</td>
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<tr>
<td>Mr J. M. RITTER ARITA, Minister Counsellor, Permanent Mission of the Republic of Honduras to the United Nations Office at Geneva and the Other International Organizations in Switzerland</td>
<td></td>
</tr>
</tbody>
</table>

1 Chief Delegate from 12 May.
HUNGARY

Delegates
Professor E. SCHULTHEISZ, Minister of Health (Chief Delegate)
Dr L. SÁNDOR, Head, Department of International Relations, Ministry of Health (Deputy Chief Delegate)
Professor I. FORGÁCS, Vice-Rector and Director, Institute of Social Medicine, Postgraduate School of Medicine, Budapest

Alternates
Dr Zsuzsanna JAKAB, Head, International Organizations Section, Department of International Relations, Ministry of Health
Mrs E. OLASZ, First Secretary, Ministry of Foreign Affairs

Advisers
Dr L. ELIÁS, Ministerial Counsellor, 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
Dr P. SIGURDSSON, Secretary General, Ministry of Health and Social Security (Chief Delegate)
Mr A. GRÍMSSON, Chief, International Health Affairs, Ministry of Health and Social Security (Deputy Chief Delegate)¹
Mr V. ÁRSAEÍSSON, Minister Counsellor, Deputy Permanent Representative of Iceland to the United Nations Office and the Other International Organizations at Geneva

Alternates
Dr G. MAGNÚSSON, Deputy Chief Medical Officer, Ministry of Health and Social Security
Professor J. HALLGRÍMSSON, Professor of Medicine, University of Iceland

Adviser
Mr H. HAFSTEIN, Ambassador, Permanent Representative of Iceland to the United Nations Office and the Other International Organizations at Geneva

¹ Chief Delegate from 12 May.

INDIA

Delegates
Mr B. SHANKARANAND, Union Minister of Health and Family Welfare (Chief Delegate)
Mr C. R. VAIDYANATHAN, Secretary, Ministry of Health and Family Welfare (Deputy Chief Delegate)²
Mr M. DUBEY, Ambassador, Permanent Representative of India to the United Nations Office and the Other International Organizations at Geneva

Alternates
Mr P. P. CHAUHAN, Joint Secretary, Ministry of Health and Family Welfare
Dr D. B. BISHT, Director General of Health Services, Ministry of Health and Family Welfare
Mr N. S. BAKSHI, Director of Community Health Services and Private Secretary to the Union Minister of Health and Family Welfare

Advisers
Mr B. BALAKRISHNAN, First Secretary, Permanent Mission of India to the United Nations Office and the Other International Organizations at Geneva
Mrs L. PURI, First Secretary, Permanent Mission of India to the United Nations Office and the Other International Organizations at Geneva

INDONESIA

Delegates
Dr S. SURYANINGRAT, Minister of Health (Chief Delegate)
Dr M. ISA, Director General of Medical Care, Ministry of Health
Dr I. B. MANTRA, Director of Health Education, Ministry of Health

Alternate
Dr Sriati DA COSTA, Chief, Centre for Health Data, Planning Bureau, Ministry of Health

Advisers
Mr I. DARSA, Ambassador, Permanent Representative of the Republic of Indonesia to the United Nations Office and the Other International Organizations at Geneva
Dr W. B. WANANDI, Technical Adviser to the Minister of Health

² Chief Delegate from 14 May.
Mr. N. Wisnoemoerti, Counsellor, Permanent Mission of the Republic of Indonesia to the United Nations Office and the Other International Organizations at Geneva

Miss R. Tanzil, Third Secretary, Permanent Mission of the Republic of Indonesia to the United Nations Office and the Other International Organizations at Geneva

**Iran (Islamic Republic of)**

**Delegates**
- Dr. H. Manafi, Minister of Health (Chief Delegate)
- Dr. A. Marandi, Under-Secretary for Health Affairs, Ministry of Health (Deputy Chief Delegate)
- Dr. B. Sadrizadeh, Director General, Department of Family Health, Ministry of Health

**Alternates**
- Mr. M. A. Abbassi Tehrani, Director General, Department of International Relations, Ministry of Health
- Dr. H. Vakil, Expert in Medical Education, Ministry of Health

**Advisers**
- Mr. N. Kazemi-Kamyab, Ambassador, Permanent Representative of the Islamic Republic of Iran to the United Nations Office and the Other International Organizations at Geneva
- Dr. M. Moin Najafabadi, Assistant Professor of Medicine, University of Teheran; Member of the Health Commission of the Islamic Consultative Assembly
- Dr. H. Malek Afzali, Assistant Professor of Biostatistics, School of Public Health, University of Teheran
- Mr. F. Shahabi, First Secretary, Permanent Mission of the Islamic Republic of Iran to the United Nations Office and the Other International Organizations at Geneva
- Mr. A. Shafii, Second Secretary, Permanent Mission of the Islamic Republic of Iran to the United Nations Office and the Other International Organizations at Geneva
- Mr. J. Zahirnia, Second Secretary, Permanent Mission of the Islamic Republic of Iran to the United Nations Office and the Other International Organizations at Geneva
- Mr. M. A. Kalami, Attaché, Permanent Mission of the Islamic Republic of Iran to the United Nations Office and the Other International Organizations at Geneva

**1 Chief Delegate from 15 May.**

Mr. H. Motallebi, Attaché, Permanent Mission of the Islamic Republic of Iran to the United Nations Office and the Other International Organizations at Geneva

**Iraq**

**Delegates**
- Dr. S. H. Alwash, Minister of Health (Chief Delegate)
- Dr. A. H. Al-Taweel, President of the General Foundation for Health Education and Training, Ministry of Health
- Mr. I. Mahboub, Minister Plenipotentiary, Chargé d'Affaires, Permanent Mission of the Republic of Iraq to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

**Alternates**
- Dr. M. Al-Najjar, Director-General of Health Relations, Ministry of Health
- Dr. A. Hassoun, Director of International Health Affairs, Ministry of Health
- Mr. N. Al-Badrani, Minister Plenipotentiary, Permanent Mission of the Republic of Iraq to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
- Dr. S. S. Morkas, Deputy Director-General for Preventive Medicine and Environmental Health, Ministry of Health

**Advisers**
- Professor S. Al-Tikriti, Professor of Community Medicine, College of Medicine, University of Baghdad
- Dr. B. Majeed, Ministry of Health
- Dr. A. Jomard, First Secretary, Permanent Mission of the Republic of Iraq to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

**Ireland**

**Delegates**
- Dr. J. H. Walsh, Deputy Chief Medical Officer, Department of Health (Chief Delegate)
- Mr. F. M. Hayes, Ambassador, Permanent Representative of Ireland to the United Nations Office and the Specialized Agencies at Geneva
- Mr. J. D. Biggar, First Secretary, Permanent Mission of Ireland to the United Nations Office and the Specialized Agencies at Geneva
Advisers

Professor B. LEONARD, Department of Pharmacology, University College, Galway
Mr M. LYONS, Assistant Principal Officer, Department of Health
Mr M. CRADDOCK, Attaché, Permanent Mission of Ireland to the United Nations Office and the Specialized Agencies at Geneva

Delegates

Mr E. SHOSTAK, Minister of Health (Chief Delegate)
Professor B. MODAN, Director-General, Ministry of Health (Deputy Chief Delegate) ¹
Mr E. DOWEK, Ambassador, Permanent Representative of Israel to the United Nations Office and the Specialized Agencies at Geneva

Alternates

Professor B. LUNENFELD, Counsellor for External Relations, Ministry of Health ³
Mr M. YEDID, Assistant Director, International Organizations Division, Ministry of Foreign Affairs
Professor M. PRYWES, Chair for Medical Education, Faculty of Health Sciences, Ben Gurion University of the Negev
Professor A. M. DAVIES, Director, School of Public Health, Hebrew University of Jerusalem
Mr D. DANIELI, First Secretary, Permanent Mission of Israel to the United Nations Office and the Specialized Agencies at Geneva

Delegates

Mr C. DEGAN, Minister of Health (Chief Delegate)
Professor V. A. DI LEO, Director, Office of International Relations, Ministry of Health (Deputy Chief Delegate)
Professor L. GIANNICO, Director-General of Public Health, Ministry of Health ⁴

Alternates

Professor D. POGGIOLINI, Director-General of the Pharmaceutical Service, Ministry of Health
Mr L. POLITI, Director-General, Food and Nutrition Services, Ministry of Health
Professor F. POCCHIARI, Director-General, Istituto Superiore di Sanità
Professor B. PACCAGNELLA, Director, Institute of Hygiene, University of Padua
Mr E. DE MAIO, Counsellor, Permanent Mission of Italy to the United Nations Office and the Other International Organizations at Geneva

Delegates

Mr F. FORMICA, Second Secretary, Permanent Mission of Italy to the United Nations Office and the Other International Organizations at Geneva
Dr G. BERTOLASO, Department of Development Cooperation, Ministry of Foreign Affairs
Dr Silvia CASTORINA, Office of International Relations, Ministry of Health
Dr Marcella MARLETTA, Office of International Relations, Ministry of Health
Mr A. PAGANINI, Department of Development Cooperation, Ministry of Foreign Affairs
Dr Marta DI GENNARO, Department of Development Cooperation, Ministry of Foreign Affairs
Mr E. ROCCO, Office of International Relations, Ministry of Health

Advisers

Dr F. L. ODDO, Technical Adviser, Office of International Relations, Ministry of Health
Dr V. FATTORUSSO, Ministry of Health
Professor G. LOJACONO, Director, Social Security Service, Institute of Studies for Economic Programming
Dr G. STERLICCHIO, Chef de cabinet to the Minister of Health

Delegates

Professor A. DJEDJE WADY, 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 (Deputy Chief Delegate)
Dr L. KONE, Director of International and Regional Relations, Ministry of Public Health and Population

¹ Chief Delegate on 12 May.
² Deputy Chief Delegate on 12 May, Chief Delegate from 14 May.
³ Deputy Chief Delegate from 14 May.
⁴ Deputy Chief Delegate from 10 May.
### Alternates

| Professor G. GUESSENND KOUADIO, Director of Studies, National Institute of Public Health, Abidjan |
|Professor K. P. EKRA, Counsellor, Permanent Mission of the Republic of the Ivory Coast to the United Nations Office and the Specialized Agencies at Geneva |

### Delegates

| Dr. K. 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 |
| Mrs. C. C. PARKER, Director of Finance, Ministry of Health |

### Advisers

| Miss C. CLAYTON, Minister Counsellor, Permanent Mission of Jamaica to the United Nations Office and the Specialized Agencies at Geneva |
| Miss V. E. BETTON, First Secretary, Permanent Mission of Jamaica to the United Nations Office and the Specialized Agencies at Geneva |

### JAMAICA

### Delegates

| Mr. K. CHIBA, Ambassador Extraordinary and Plenipotentiary, Permanent Representative of Japan to the United Nations Office and the Other International Organizations at Geneva (Chief Delegate) |
| Mr. W. YAMASHITA, Vice-Minister for Health and Welfare |
| Dr. E. NAKAMURA, Director-General, Statistics and Information Department, Minister's Secretariat, Ministry of Health and Welfare |

### Alternates

| Dr. A. GUNJI, Director, Biologics and Antibiotics Division, Pharmaceutical Affairs Bureau, Ministry of Health and Welfare |
| Mr. H. SATO, Counsellor, Permanent Mission of Japan to the United Nations Office and the Other International Organizations at Geneva |
| Mr. H. ASAHI, First Secretary, Permanent Mission of Japan to the United Nations Office and the Other International Organizations at Geneva |

### JAPAN

### Delegates

| Dr. K. AL-AJLOUNI, Minister of Health (Chief Delegate) |
| Dr. Y. M. ISSA, Director, Department of Administrative and Financial Affairs, Ministry of Health |
| Dr. H. OWEIS, Head, Department of Hospital Administration, Ministry of Health |

### Alternates

| Mr. H. MUHAISEN, Minister Plenipotentiary, Permanent Mission of the Hashemite Kingdom of Jordan to the United Nations Office at Geneva and the Specialized Agencies in Switzerland |
| Dr. S. HIJAZI, Dean, Faculty of Medicine, Yarmouk University, Irbid |
| Dr. K. SHAKER, Director, Centre for Medical Education, University of Jordan |

### Adviser

| Dr. M. MA’ABREH, Head, Chest Diseases Division, Ministry of Health |

### KENYA

### Delegates

| Mr. K. M'MBIJJEWE, Minister for Health (Chief Delegate) |

### Members of the Health Assembly
Mr J. A. K. KIPSANAI, Permanent Secretary, Ministry of Health
Dr W. KOINANGE, Director of Medical Services, Ministry of Health

Alternates
Professor D. GATEI, College of Health Sciences, University of Nairobi
Mrs M. MATI, Deputy Chief Nursing Officer, Kenyatta National Hospital, Nairobi

KUWAIT

Delegates
Dr A. R. AL-AWADI, Minister of Public Health and Minister of Planning (Chief Delegate)
Dr A. AL-SAIF, Head, Division of International Health Relations and Deputy Head, Division of Preventive Medicine, Ministry of Public Health
Dr A. K. KARAM, Director, Department of District Hospitals, Ministry of Public Health

Alternates
Mr M. TAWFIQ, Legal Adviser, Ministry of Public Health
Dr A. ALREFAI, Secretary General, University of Kuwait
Mr A. Y. AL-JASMI, Research Officer, Ministry of Public Health

Advisers
Mr N. AL-NAKHILAN, Research Officer, Ministry of Public Health
Miss B. AL-SHAMALI, Research Officer, Ministry of Public Health
Miss M. M. AL-ROUMI, Research Officer, Ministry of Public Health

LIBERIA

Delegates
Mrs M. K. SELLER, Minister of Health and Social Welfare (Chief Delegate)
Dr I. CAMANOR, Deputy Chief Medical Officer, Ministry of Health and Social Welfare
Dr J. N. TOGBA

Alternates
Dr A. HANSON, Director of Biomedical Research (Parasitology)

LIBYAN ARAB JAMAHIRIYA

Delegates
Professor M. LENGHI, Secretary, People's General Committee for Health (Chief Delegate)
Professor A. M. ZLITNI, Secretary, People's General Committee for Education
Professor B. SAGHER, Counsellor for Health Affairs, Permanent Mission of the Socialist People's Libyan Arab Jamahiriya to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Alternates
Dr A. GEBREEL, Director-General of Public Health Care, Secretariat for Health
Dr A. SHARIF, Director of the Libyan Red Crescent, Secretariat for Health
Mr S. SHEBANI, Permanent Representative of the Socialist People's Libyan Arab Jamahiriya to the United Nations Educational, Scientific and Cultural Organization in Paris
Mr K. NAAS, Secretariat for Education
**MEMBERSHIP OF THE HEALTH ASSEMBLY**

**Advisers**
- Mr. D. M. Tumi, Secretariat for Health
- Mr. M. Duaia, Secretariat for Health

**Luxembourg**

**Delegates**
- Mr. E. Krieps, Minister of Health (Chief Delegate)
- Dr. E. J. P. Duhr, Director of Health, Ministry of Health (Deputy Chief Delegate)
- Mr. J. Rettel, Ambassador, Permanent Representative of the Grand Duchy of Luxembourg to the United Nations Office at Geneva

**Alternates**
- Dr. J. Kohl, Deputy Director of Health, Ministry of Health
- Dr. Danielle Hansen-Koenig, Chief Physician, Division of Preventive and Social Medicine, Ministry of Health
- Mr. J.-L. Wolzfeld, Counsellor, Deputy Permanent Representative of the Grand Duchy of Luxembourg to the United Nations Office at Geneva

**Madagascar**

**Delegates**
- Professor E. Andriamampihantona, Secretary General, Ministry of Health (Chief Delegate)
- Mr. J. Rasolofonirina, Chief, International Relations Section, Ministry of Health
- Dr. Carombène R. RatomaHenina, Assistant Medical Officer, Prosthetic Appliances Supply Centre, Ministry of Health

**Alternates**
- Dr. J. Kohl, Deputy Director of Health, Ministry of Health
- Dr. Danielle Hansen-Koenig, Chief Physician, Division of Preventive and Social Medicine, Ministry of Health
- Mr. J.-L. Wolzfeld, Counsellor, Deputy Permanent Representative of the Grand Duchy of Luxembourg to the United Nations Office at Geneva

**Malaysia**

**Delegates**
- Mr. Chin Hon Ngian, Minister of Health (Chief Delegate)
- Mr. A. Faiz, Ambassador, Permanent Representative of Malaysia to the United Nations Office and Other International Organizations at Geneva (Deputy Chief Delegate)
- Dr. Gurmukh Singh, Director of Medical and Health Services, Ministry of Health

**Alternates**
- Dr. C. Mohammed Noor, Director of Medical and Health Services, Trengganu
- Dr. Tan Koon San, Deputy Permanent Representative of Malaysia to the United Nations Office and Other International Organizations at Geneva

**Mali**

**Delegates**
- Dr. N. Traoré, Minister of Public Health and Social Affairs (Chief Delegate)
- Dr. C. Traoré, National Director of Public Health, Ministry of Public Health and Social Affairs
- Mr. S. Doucouré, Attaché de cabinet to the Minister of Public Health and Social Affairs

**Alternates**
- Dr. A. N. Diallo, Assistant Head of Clinic, School of Medicine and Pharmacy, Bamako
- Dr. S. A. Konaré, Head, Division of Epidemiology and Preventive Services, Ministry of Public Health and Social Affairs

**Malta**

**Delegates**
- Dr. V. Moran, Minister of Health and Environment (Chief Delegate)
THIRTY-SEVENTH WORLD HEALTH ASSEMBLY

Dr A. GRECH, Chief Medical Officer, Ministry of Health (Deputy Chief Delegate)

Mr E. C. FARRUGIA, Counsellor, Deputy Permanent Representative of the Republic of Malta to the United Nations Office and the Specialized Agencies at Geneva

Alternates
Dr J. GRECH ATTARD, Adviser, Ministry of Health
Mr J. CARUANA, Adviser, Ministry of Health
Professor E. SCICLUNA, Department of Management Studies, University of Malta

MAURITANIA

Delegates
Mr M. M. OULD DEH, Minister of Health and Labour (Chief Delegate)
Dr M. M. OULD HACEN, Technical Adviser, Ministry of Health and Labour
Dr M. BA, Director of Public Health, Ministry of Health and Labour

MAURITIUS

Delegates
Mr R. PURRYAG, Minister of Health (Chief Delegate)
Mr D. RAMYEAD, Permanent Secretary, Ministry of Health

MEXICO

Delegates
Dr G. SOBERÓN ACEVEDO, Secretary for Health and Welfare (Chief Delegate)
Dr M. QUIJANO, Director of International Affairs, Secretariat for Health and Welfare (Deputy Chief Delegate)
Dr B. SEPULVEDA, Secretary, General Health Council, Secretariat for Health and Welfare

Alternates
Dr F. HERRERA-LASSO, Director of Medical Education and Research, Secretariat for Health and Welfare
Dr Blanca R. ORDÓÑEZ, Director, Epidemiology Division, Secretariat for Health and Welfare
Dr A. DE WIT, Assistant Medical Director, State Employees' Social Security Institute
Dr O. RIVERO SERRANO, Rector, National Autonomous University of Mexico

Professor A. PIÑEYRO, Rector, Autonomous University of Nuevo León
Dr A. GÓMEZ RODRÍGUEZ, Director, School of Postgraduate Studies, University of Guadalajara
Miss O. GARRIDO-RUÍZ, Third Secretary, Permanent Mission of Mexico to the United Nations Office at Geneva and the Other International Organizations in Switzerland

MONACO

Delegates
Dr E. BOÉRI, Technical Adviser, Permanent Delegate of the Principality of Monaco to the International Health Organizations (Chief Delegate)
Mr D.-L. GASTAUD, Director, Health and Social Affairs, Ministry of State

MONGOLIA

Delegates
Mr D. NYAM-OSOR, Minister of Public Health (Chief Delegate)
Dr Z. JADAMBA, Chief, Department of Foreign Relations, Ministry of Public Health
Mr T. ZORIGTBAATAR, Attaché, Permanent Mission of the People's Republic of Mongolia to the United Nations Office and the Other International Organizations at Geneva

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 (Deputy Chief Delegate)
Mr O. JENNANE, Secretary-General, Ministry of Public Health

Alternates
Mr M. FERAA, Inspector-General, Ministry of Public Health
Dr N. FIKRI-BENBRAHIM, Chief, Division of Epidemiology and Director of External Relations, Ministry of Public Health
Dr A. EL MANSOURI, Chief Physician, Province of Marrakesh
Professor M. D. ARCHANE, Medical Officer of the Royal Armed Forces
Professor A. JOUHAR-OUARAIṈI, Director of the Office of the Minister of Public Health
Mr O. HILAŁE, First Secretary, Permanent Mission of the Kingdom of Morocco to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Dr M. AKHMISSÉ, Chief Physician, Medical Prefecture of Casablanca-Anfa

MOZAMBIQUE

Delegates
Dr P. M. MOCUNBI, Minister of Health (Chief Delegate)
Dr A. J. R. CÁBRAL, Director of Preventive Medicine, Ministry of Health

NEPAL

Delegates
Mr N. D. BHATTAC, Minister for Health, Industry and Commerce (Chief Delegate)
Dr D. N. REČMI, Director General of Health Services, Ministry of Health
Dr K. B. SINGH, Chief, Expanded Immunization Project, Ministry of Health

Alternate
Mr P. L. SHRESTHÁ, Chargé d'Affaires, First Secretary, Permanent Mission of the Kingdom of Nepal to the United Nations Office and the Other International Organizations at Geneva

NETHERLANDS

Delegates
Mr J. P. VAN DER REYDEN, State Secretary of Welfare, Health and Cultural Affairs (Chief Delegate)
Dr J. VAN LONDEN, Director-General of Health, Ministry of Welfare, Health and Cultural Affairs
Mr F. ZANDVLIET, Head, Staff Bureau for International Health Affairs, Ministry of Welfare, Health and Cultural Affairs

Alternates
Dr J. A. C. DE KOCK VAN LEEUWEN, Adviser to the Director-General of Health, Ministry of Welfare, Health and Cultural Affairs
Dr C. O. PANNENBORG, Chief, Strategic Health Planning, Staff Bureau for Policy Development, Ministry of Welfare, Health and Cultural Affairs

1 Chief Delegate from 14 May.

Miss M. A. VAN DRUNEN LITTEL, International Organizations Department, Ministry of Foreign Affairs
Mr K. G. WIT, Development Cooperation Department, Ministry of Foreign Affairs
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

Advisers
Mr R. J. VAN SCHAUK, 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 and Environmental Hygiene, Bilthoven, Ministry of Welfare, Health and Cultural Affairs
Mr R. J. SAMSOM, Director-in-chief, Health Protection Branch, Ministry of Welfare, Health and Cultural Affairs

NEW ZEALAND

Delegates
Dr R. BARKER, Director-General of Health, Department of Health (Chief Delegate)
Miss A. WARNER, Assistant Director, Division of Nursing, Department of Health
Professor C. J. HEATH, Associate Dean for Undergraduate Studies, Faculty of Medicine, University of Otago, Dunedin

Alternates
Mr R. E. B. PEREN, Ambassador, Permanent Representative of New Zealand to the United Nations Office at Geneva
Mr B. LINNÉHAM, Counsellor, Deputy Permanent Representative of New Zealand to the United Nations Office at Geneva
Miss H. RIDDELL, Third Secretary, Permanent Mission of New Zealand to the United Nations Office at Geneva

NICARAGUA

Delegates
Mrs L. GUIDO, Minister of Health (Chief Delegate)
Mr G. A. VARGAS, Ambassador, Permanent Representative of Nicaragua to the United Nations Office and the Other International Organizations at Geneva
Dr P. CASTELLÓN, Director of International Relations, Ministry of Health
THIRTY-SEVENTH WORLD HEALTH ASSEMBLY

Alternate
Mr A. M. BARRIOS, Chef de cabinet to the Minister of Health

NIGER

Delegates
Dr A. MOUDI, Minister of Public Health and Social Affairs (Chief Delegate)
Dr L. LOCO, Deputy Director of Hygiene and Mobile Medicine, Ministry of Public Health and Social Affairs
Dr I. SOFO, Deputy Departmental Director of Health, Niamey, Ministry of Public Health and Social Affairs

NIGERIA

Delegates
Mr P. S KOSHONI, Federal Minister of Health (Chief Delegate)
Mr D. MOHAMMAD, Permanent Secretary, Federal Ministry of Health (Deputy Chief Delegate)
Dr C. T. O. CHORI, Chief Consultant, Directorate of Medical Services and Training, Federal Ministry of Health

Alternates
Dr G. WILLIAMS, Chief Consultant, Directorate of Public Health Services, Federal Ministry of Health
Mr N. E. ONYENANU, Principal Secretary (State and External Relations), Federal Ministry of Health

Advisers
Mr A. U. ABUBAKAR, Second Secretary, Permanent Mission of the Federal Republic of Nigeria to the United Nations Office and the Other International Organizations at Geneva
Mr C. V. UDEDEBIA, Second Secretary, Permanent Mission of the Federal Republic of Nigeria to the United Nations Office and the Other International Organizations at Geneva
Professor T. A. I. GRILLO, Faculty of Health Sciences, University of Ife

NORWAY

Delegates
Dr Astrid N. HEIBERG, State Secretary, Ministry of Social Affairs (Chief Delegate)

Dr T. MORK, Director-General of Health Services, Directorate of Health (Deputy Chief Delegate)¹
Dr O. T. CHRISTIANSEN, Deputy Director, Directorate of Health

Alternate
Mr B. S. UTHEIM, Minister Counsellor, Deputy Permanent Representative of Norway to the United Nations Office and the Other International Organizations at Geneva

Advisers
Mrs G. VANDESKOG, Head of division, Ministry of Social Affairs
Dr Anne ALVIK, Deputy County Medical Director, Akershus County
Mrs M. BERGGRAV, Senior Executive Officer, Norwegian Agency for International Development
Mr H. P. LEHNNE, Second Secretary, Permanent Mission of Norway to the United Nations Office and the Other International Organizations at Geneva
Professor B. A. WAALER, Rector, University of Oslo
Mrs N. H. JAKOBSEN, University of Tromsø

OMAN

Delegates
Dr M. AL-KHADURI, Minister of Health (Chief Delegate)
Dr A. A. K. AL-GHASSANY, Director, Department of Preventive Medicine, Ministry of Health²
Mr M. AL-ZARRAFY, First Secretary, Permanent Mission of the Sultanate of Oman to the United Nations Office at Geneva

Alternate
Mr Z. AL-MANTHRI, Administrative Officer, Minister's Office, Ministry of Health

Advisers
Dr A. R. FERGANY, Adviser on Health Affairs, Ministry of Health
Mr S. AL-MISKARY, Counsellor, Permanent Mission of the Sultanate of Oman to the United Nations Office at Geneva

PAKISTAN

Delegates
Professor B. JAZBI, Minister for Health, Special Education and Social Welfare (Chief Delegate)

¹ Chief Delegate from 11 May.
² Chief Delegate from 14 May.
MEMBERSHIP OF THE HEALTH ASSEMBLY

PAPUA NEW GUINEA

Delegates
Mr M. P. TO VADEK, Minister of Health (Chief Delegate)
Dr L. STALIS, Coordinator, Health Services Administration, Department of Health (Deputy Chief Delegate)
Mr P. EAPAE, Assistant Secretary, Division of Health, Department of Western Highlands

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 R. VILLARAN KOECHLIN, Ambassador, Permanent Representative of Peru to the United Nations Office and the Other International Organizations at Geneva (Deputy Chief Delegate)
Dr J. DE VINATEA COLLINS, Director-General of International Relations, Ministry of Health

PHILIPPINES

Delegates
Dr A. N. ACOSTA, Deputy Minister of Health (Chief Delegate)
Mr H. J. BRILLANTES, Ambassador,
Permanent Representative of the
Philippines to the United Nations
Office and the Other International
Organizations at Geneva
Dr F. SANCHEZ, Dean, College of Medicine,
University of the East

Alternate
Mrs V. SISANTE-BATACLAN, Third Secretary,
Permanent Mission of the Philippines to
the United Nations Office and the Other
International Organizations at Geneva

POLAND

Delegates
Dr T. SZEŁACHOWSKI, Minister of Health and
Social Welfare (Chief Delegate)
Professor W. RUDOWSKI, Director, Institute
of Haematology, Warsaw
Professor J. SZCZERZAN, Deputy Director,
Institute of Surgery, Warsaw

Alternates
Professor J. NAUMAN, Chief, Institute of
Biochemistry, Post-Graduate Medical
Training Centre, Warsaw
Professor J. INDULSKI, Director,
Institute of Labour Medicine in the
Textile and Chemical Industry, Łódź

Advisers
Mrs I. GŁOWACKA, Deputy Director
Department of International Relations,
Ministry of Health and Social Welfare
Mrs B. BITNER, Department of International
Relations, Ministry of Health and
Social Welfare
Mr T. STROJWAS, First Secretary, Permanent
Mission 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)
Mr J. RITTO, Minister Plenipotentiary,
Assistant Director General of
Cooperation, Ministry of Foreign Affairs
Dr A. BARREIROS SANTOS, Secretariat of
State for Emigration

Alternates
Dr M. M. de J. PINHO DA SILVA, Director,
Health Services of Macao

Mr A. PINTO DE LEMOS, Counsellor (Economic
Affairs), Permanent Mission of Portugal
to the United Nations Office and the
Other International Organizations at Geneva
Mr M. JORDÃO, Attaché (Social and Labour
Affairs), Permanent Mission of Portugal
to the United Nations Office and the
Other International Organizations at Geneva

QATAR

Delegates
Mr K. AL-MANA, Minister of Public Health
(Chief Delegate)
Mr A. AL-ASSIRY, Assistant Under-Secretary
for Administration and Finance,
Ministry of Public Health
Dr K. AL-JABER, Director of Preventive
Medicine, Ministry of Public Health

Alternates
Mr M. ABU-ALFAIN, Director, Office of the
Minister of Public Health
Dr J. AJAJ, Legal Adviser, Ministry of
Public Health

REPUBLIC OF KOREA

Delegates
Mrs Chung Rye KIM, Minister of Health and
Social Affairs (Chief Delegate)
Mr Sang Yong PARK, Ambassador, Permanent
Observer of the Republic of Korea to
the United Nations Office and Permanent
Delegate to the Other International
Organizations at Geneva (Deputy Chief
Delegate)
Dr Sung Woo LEE, Director-General, Bureau
of Medical Affairs, Ministry of Health and
Social Affairs

Alternates
Mr Jong Koo AHN, Director, International
Organizations Division, Ministry of
Foreign Affairs
Mr Hong Suk HWANG, Director,
International Affairs Division,
Ministry of Health and Social Affairs
Mr Seock Jeong EOM, Second Secretary,
Office of the Permanent Observer of the
Republic of Korea to the United Nations
Office and Permanent Delegation to the
Other International Organizations at
Geneva
Mr Sang Yun CHUNG, Secretary to the
Minister, International Affairs
Division, Ministry of Health and Social
Affairs
MEMBERSHIP OF THE HEALTH ASSEMBLY

ROMANIA

Delegates
Mr I. DATCU, Ambassador, Permanent Representative of the Socialist Republic of Romania to the United Nations Office and the Specialized Agencies at Geneva (Chief Delegate)
Mr T. MELESCANU, Counsellor, Permanent Mission of the Socialist Republic of Romania to the United Nations Office and the Specialized Agencies at Geneva (Deputy Chief Delegate)
Mr P. BALOIU, First Secretary, Permanent Mission of the Socialist Republic of Romania to the United Nations Office and the Specialized Agencies at Geneva

Alternate
Mr M. BICHIR, First Secretary, Permanent Mission of the Socialist Republic of Romania to the United Nations Office and the Specialized Agencies at Geneva

RWANDA

Delegates
Dr F. MUGANZA, Minister of Public Health and Social Affairs (Chief Delegate)
Dr J.-B. RWASINE, Director-General of Pharmacies, Ministry of Public Health and Social Affairs
Dr J.-B. KANYAMUPIRA, Medical Director, University Centre of Public Health, Butare

SAO TOME AND PRINCIPE

Delegates
Dr F. J. H. SEQUEIRA, Minister of Health and Sports (Chief Delegate)
Dr A. S. M. DE LIMA, Director of Medical Assistance, Ministry of Health and Sports
Dr Juliana AFONSO NOBRE DOS RAMOS, Director, National Centre for Health Education, Ministry of Health and Sports

SAUDI ARABIA

Delegates
Mr A. A. AL-SHEIKH, Minister of Agriculture and Water Resources, and Acting Minister of Health (Chief Delegate)
Dr N. NASSIEF, Deputy Minister for Executive Affairs, Ministry of Health (Deputy Chief Delegate)
Professor A. A. H. AL-JABARTY, Assistant Deputy Minister for Manpower Development, Ministry of Health

Alternate
Mr N. H. QUTUB, Specialist for International Conference Affairs and Secretary to the Minister of Health
Dr A.-A. AL-MASHARI, Dean, Faculty of Paramedical Sciences, King Saud University

SAN MARINO

Delegates
Dr Emma ROSSI, Minister of Health and Social Security (Chief Delegate)
Dr D. MANZAROLI, Vice-Director of the State Hospital
Dr N. SIMETOVIC, Deputy Head, State Hospital

Alternates
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
Dr C. DE BENEDETTI, Minister Plenipotentiary, Deputy Permanent Observer of the Republic of San Marino to the United Nations Office and Deputy Permanent Delegate to the Other International Organizations in Switzerland

SENEGAL

Delegates
Mr M. DIOP, Minister of Public Health (Chief Delegate)
Mr A. SENE, Ambassador, Permanent Representative of the Republic of Senegal to the United Nations Office and the Specialized Agencies at Geneva (Deputy Chief Delegate)
<table>
<thead>
<tr>
<th>Country</th>
<th>Delegate</th>
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<tbody>
<tr>
<td>Thailand</td>
<td>Mr Y. RAHMAN, Third Secretary, Permanent Mission of the Republic of Singapore</td>
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<td>to the United Nations Office and the Specialized Agencies at Geneva</td>
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<td>SOLOMON ISLANDS</td>
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<td>Dr P. OGATUTI, Under-Secretary for Health, Ministry of Health and Medical</td>
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<td>Dr ABDIRASHID SHEIKH AHMED, Deputy Minister of Health (Chief Delegate)</td>
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<td>Mr A. S. OSMAN, Ambassador, Permanent Representative of the Somali Democratic</td>
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<td>Republic to the United Nations Office and the Specialized Agencies in</td>
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<td>Switzerland (Deputy Chief Delegate)</td>
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<td>Dr K. M. SUFI, Adviser to the Minister of Health</td>
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<td>Alternates</td>
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<tr>
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<td>Dr A. SHERIF ABBAS, Adviser on Maternal and Child Health and Nutrition,</td>
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<td>Ministry of Health</td>
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<td>Dr H. BARRE MUSSE, Director, Department of Medical Equipment and Drugs,</td>
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<td>Dr A. K. SHIRE, Director, Department of Curative Medicine, Ministry of</td>
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<td>Mrs F. ENO-HASSAN, Second Counsellor, Permanent Mission of the Somali</td>
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<td>Democratic Republic to the United Nations Office at Geneva and the</td>
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<td>Specialized Agencies in Switzerland</td>
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<td>Mr A. M. NAJJB, Third Counsellor, Permanent Mission of the Somali</td>
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<td>SPAIN</td>
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<td>Delegates</td>
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<td>Professor E. LLUCH, Minister of Health and Consumer Affairs (Chief</td>
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<td>Delegate)</td>
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<td>Mr P. SABANDO, Under-Secretary, Ministry of Health and Consumer Affairs</td>
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<td>Professor E. NAJERA, Director General of Public Health, Ministry of Health</td>
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<td>Mr J. PELEGRI, Secretary-General (Technical Affairs), Ministry of Health</td>
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Mr J. ARTIGAS, Director of the Office of the Minister of Health and Consumer Affairs
Mr J. I. NAVARRO, Minister Plenipotentiary, Deputy Permanent Representative of Spain to the United Nations Office at Geneva and Other International Organizations in Switzerland
Mr F. MONFORT, Assistant Director General of Cooperation with International Development Organizations, Ministry of Foreign Affairs

Al M. B. L. S. R. AL SARRAG, Commissioner for Health Affairs, Ministry of Health (Deputy Chief Delegate)

SRI LANKA

Delegates
Dr R. ATAPATTU, Minister of Health (Chief Delegate)
Mr L. PANAMBALANA, Secretary, Ministry of Health
Dr M. FERNANDO, Director General of Health Services, Ministry of Health

Alternate
Mr P. KARIYAWASAM, Third Secretary, Permanent Mission of the Democratic Socialist Republic of Sri Lanka to the United Nations Office and the Other International Organizations at Geneva

SUDAN

Delegates
Dr A. S. S. EISA, Minister of Health (Chief Delegate)
Dr M. S. AL SARRAG, Commissioner for Health Affairs, Ministry of Health (Deputy Chief Delegate)

Mr I. A. O. HAMRA, Ambassador, Deputy Permanent Representative of the Democratic Republic of Sudan to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Alternates
Mr Y. ISMAIL, Minister Plenipotentiary, Permanent Mission of the Democratic Republic of Sudan to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Dr Z. A. NUR, Acting Director-General of International Health, Ministry of Health

Mr M. I. BABIKER, Permanent Representative of the Democratic Republic of Sudan to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Mr Y. ABDELGALIL, Second Secretary, Permanent Mission of the Democratic Republic of Sudan to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

SURINAME

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Dr R. E. VAN TRIKT, Minister of Health and Environment (Chief Delegate)
Dr H. TJON JAW CHONG, Acting Director of Health, Ministry of Health
Dr W. VAN KANTEN, Director, Institute for Biomedical Sciences, University of Suriname

SWAZILAND

Delegates
H. R. H. Prince PHIWOKWAKHE, Minister of Health (Chief Delegate)
Mr H. B. MALAHA, Acting Principal Secretary, Ministry of Health (Deputy Chief Delegate)
Dr Z. M. DLAMINI, Director of Medical Services, Ministry of Health

Alternate
Dr Ruth TSHABALALA, Senior Medical Officer, Ministry of Health

SWEDEN

Delegates
Mrs C. SIGURDSEN, Minister of Health and Social Affairs (Chief Delegate)
Dr Barbro WESTERHOLM, Director General, National Board of Health and Welfare (Deputy Chief Delegate)¹

¹ Chief Delegate from 9 May.
Mr. G. DAHLGREN, Head of department, Ministry of Health and Social Affairs

Alternates
Mr. H. V. EWERLOF, Ambassador, Permanent Representative of Sweden to the United Nations Office and the Other International Organizations at Geneva
Dr. V. FALK, Head of department, National Board of Health and Welfare
Miss A.-C. FILIPSSON, Head of section, Ministry of Health and Social Affairs
Mr. C.-J. GROTH, Minister Plenipotentiary, Deputy Permanent Representative of Sweden to the United Nations Office and the Other International Organizations at Geneva
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Dr. A. ÅSLUND, First Secretary, Permanent Mission of Sweden to the United Nations Office and the Other International Organizations at Geneva

Adviser
Mr. H. WESTLING, Vice-Chancellor, University of Lund

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SWITZERLAND

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Professor B. A. ROOS, Director, Federal Office of Public Health (Chief Delegate)
Mr. J.-P. VETTOVAGLIA, Minister, Deputy Head of the Permanent Mission of Switzerland to the International Organizations at Geneva (Deputy Chief Delegate)
Dr. Immita CORNAZ, Scientific Assistant, Directorate for Cooperation in Development and Humanitarian Aid, Federal Department of Foreign Affairs

Alternates
Dr. J. SCHEURER, Scientific Assistant, Federal Office of Public Health
Mr. J. E. BARTLOME, Collaborateur diplomatique, Directorate of International Organizations, Federal Department of Foreign Affairs
Miss S. BORNAND, Specialist, Federal Office of Public Health
Dr. W. FLURY, Chief, Medical Section, Intercantonal Office for Control of Drugs

Advisers
Dr. J. MARTIN, Deputy Cantonal Medical Officer, Vaud
Professor H. ROHR, Dean, Faculty of Medicine, Basle

SYRIAN ARAB REPUBLIC

Delegates
Dr. G. RIFAI, Minister of Health (Chief Delegate)
Dr. M. BAATH, Vice-Minister of Health
Dr. W. HUSSEIN, Director of International Relations, Ministry of Health

Alternate
Dr. A. DAOUDY, Ambassador, Permanent Representative of the Syrian Arab Republic to the United Nations Office and Specialized Agencies at Geneva

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Delegates
Mr. M. BUNNAG, Minister of Public Health (Chief Delegate)
Dr. A. NONDASUTA, Permanent Secretary, Ministry of Public Health
Dr. N. BHAMARAPRAVATI, Rector, Mahidol University

Alternates
Mr. C. CHINDAWONGSE, Minister Counsellor, Deputy Permanent Representative of Thailand to the United Nations Office at Geneva and the Specialized Agencies in Switzerland
Dr. D. SOONYOEN, Director, Division of Health Planning, Office of the Permanent Secretary, Ministry of Public Health

TOGO

Delegates
Mr. H. BODJONA, Minister of Public Health and Social Affairs (Chief Delegate)
Dr. B. L. SOUSSOU, Acting Chief of Medical Services, Chief Physician, Medical and Cardiology Service, University Hospital, Lomé

TONGA

Delegate
Dr. S. TAPA, Minister of Health
MEMBERSHIP OF THE HEALTH ASSEMBLY

TRINIDAD AND TOBAGO

Delegates
Dr N. GONNE, Minister of Health and Environment (Chief Delegate)
Mr L. E. WILLIAMS, 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)
Dr Elizabeth S. M. QUAMINA, Chief Medical Officer, Ministry of Health and Environment

Alternates
Mr L. BROWN, Administrative Officer, Ministry of Health and Environment
Mr O. ALI, Deputy Permanent Representative of the Republic of Trinidad and Tobago to the United Nations Office in Geneva and the Specialized Agencies in Europe
Mrs J. E. GEORGE, Counsellor, Permanent Mission of the Republic of Trinidad and Tobago to the United Nations Office in Geneva and the Specialized Agencies in Europe

TUNISIA

Delegates
Professor Souad LYACOUBI-OUACHI, Minister of Public Health (Chief Delegate)
Mr F. MEBAZAA, Ambassador, Permanent Representative of Tunisia to the United Nations Office and the Specialized Agencies in Europe (Deputy Chief Delegate)
Mr M. PEKIH, Director, Pharmacy and Drugs Unit, Ministry of Public Health

Alternates
Mrs J. DACHFOUS, Director of International Cooperation, Ministry of Public Health
Professor B. HAMZA, Director, National Institute of Child Health
Professor H. BEN AYED, Dean, Faculty of Medicine, Tunis
Professor A. SELLAMI, Dean, Faculty of Medicine, Sfax

Advisers
Mr K. EL HAFDHI, Minister Plenipotentiary, Deputy Permanent Representative of Tunisia to the United Nations Office and the Specialized Agencies at Geneva

1 Chief Delegate from 12 May.

Mr I. LEJRI, Counsellor, Permanent Mission of Tunisia to the United Nations Office and the Specialized Agencies at Geneva
Miss R. BEN LAHBIB, Head of section, Directorate of International Cooperation, Ministry of Public Health
Professor H. SAIED, Medical Inspector General, Ministry of Public Health
Mr H. BEN SOLTANE, Attaché de cabinet, Ministry of Public Health
Mr M. TLILI, Attaché, Permanent Mission of Tunisia to the United Nations Office and the Specialized Agencies at Geneva

TURKEY

Delegates
Mr I. TURKMEN, Ambassador, Permanent Representative of Turkey to the United Nations Office at Geneva and the Other International Organizations in Switzerland (Chief Delegate)
Dr E. AKER, Under-Secretary of State, Ministry of Health and Social Assistance (Deputy Chief Delegate)
Professor O. OZTÜRK, Director, Department of Psychiatry, Hacettepe University, Ankara

Alternates
Professor Münnever BERTAN, Adviser on Health Projects and International Relations, Ministry of Health and Social Assistance
Mr E. APAKAN, Counsellor, Permanent Mission of Turkey to the United Nations Office at Geneva and the Other International Organizations in Switzerland
Mr H. GÖGÜS, First Secretary, Permanent Mission of Turkey to the United Nations Office at Geneva and the Other International Organizations in Switzerland

UGANDA

Delegates
Dr E. R. NKWASIBEWE, Minister of Health (Chief Delegate)
Dr S. ETYONO, Acting Director of Medical Services, Ministry of Health
Professor R. OWOR, Dean, Makerere Medical School

Alternates
Dr S. I. OKWARE, Assistant Director of Medical Services, Ministry of Health
Dr J. T. KAKITAHL, Director of Nutrition Services; Senior Lecturer, Makerere Medical School
UNION OF SOVIET SOCIALIST REPUBLICS

Delegates
Dr S. P. BURENKOV, Minister of Health of the USSR (Chief Delegate)
Professor Ju. F. TSAKOV, Deputy Minister of Health of the USSR
Mr M. D. SYTENKO, Ambassador, Permanent Representative of the USSR to the United Nations Office and the Other International Organizations at Geneva

Advisers
Dr E. V. KOSENKO, Chief, External Relations Board, Ministry of Health of the USSR
Dr A. M. GLOTOV, Deputy Chief, External Relations Board, Ministry of Health of the USSR
Mr K. S. DIANOV, Legal Counsel, Ministry of Health of the USSR
Dr V. I. OSIPOV, Deputy Chief, Department of Research Coordination, Academy of Medical Sciences of the USSR
Mr V. V. FEDOROV, Counsellor, Permanent Mission of the USSR to the United Nations Office and the Other International Organizations at Geneva
Mr D. A. SOKOLOV, Counsellor, Department of International Economic Organizations, Ministry of Foreign Affairs of the USSR
Dr M. N. SAVELEV, Director, Department of International Health, Semaško All-Union Institute for Research on Social Hygiene and Public Health Administration, Ministry of Health of the USSR
Dr E. V. GALAHOV, Chief of unit, Foreign Health Services Department, Semaško All-Union Institute for Research on Social Hygiene and Public Health Administration, Ministry of Health of the USSR
Dr A. I. SAVINYH, Senior Inspector, External Relations Board, Ministry of Health of the USSR
Mr V. V. PUSHKAR, Senior Inspector, External Relations Board, Ministry of Health of the USSR
Professor F. E. VARTANIAN, Vice-Rector of the Order-of-Lenin Central Institute of Advanced Medical Training, Ministry of Health of the USSR

UNITED ARAB EMIRATES

Delegates
Mr H. AL-MADFA, Minister of Health (Chief Delegate)
Dr S. AL-QASSIMI, Under-Secretary, Ministry of Health
Dr A. R. JAFFAR, Assistant Under-Secretary, Ministry of Health

Alternates
Dr F. AL-QASSIMI, Assistant Under-Secretary, Ministry of Health
Dr A.-W. AL-MUHAIDEB, Assistant Under-Secretary, Ministry of Health
Dr M. H. ABDULLA, Director of Dental Services and Planning, Ministry of Health
Mr E. K. AL-MUHAIRI, Director, Department of World Health and International Relations, Ministry of Health
Mr E. ABU-HUMADE, Financial Direction, Ministry of Health
Mr Y. HUREIZ, Permanent Mission of the United Arab Emirates to the United Nations Office and the Specialized Agencies at Geneva

UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND

Delegates
Mr K. CLARKE, Minister of State for Health (Chief Delegate)¹
Dr E. L. HARRIS, Deputy Chief Medical Officer, Department of Health and Social Security (Deputy Chief Delegate)²
Dr J. J. A. REID, Chief Medical Officer, Scottish Home and Health Department

Alternates
Dr R. M. OLIVER, Chief Medical Adviser, Overseas Development Administration, Senior Principal Medical Officer, Department of Health and Social Security
Dame A. WARBURTON, Ambassador, Permanent Representative of the United Kingdom to the United Nations Office and the Other International Organizations at Geneva
Mrs A. B. POOLE, Chief Nursing Officer, Department of Health and Social Security
Mr I. G. GILBERT, Under-Secretary, Head, International Relations Division, Department of Health and Social Security
Mr G. LUPTON, Assistant Secretary, International Relations Division, Department of Health and Social Security

Advisers
Mr D. J. MOSS, Counsellor, Deputy Permanent Representative of the United Kingdom to the United Nations Office and the Other International Organizations at Geneva
Dr F. A. HYZLER, Senior Medical Officer, Department of Health and Social Security
Dr D. PEREIRA GRAY, Senior Lecturer, Department of General Practice, University of Exeter

¹ From 9 to 10 May.
² Chief Delegate on 7 and 8 May and from 11 May.
Professor Jennifer MIXER, Principal, International Relations Division, Department of Health and Social Security
Mr R. NAYSMITH, Assistant Private Secretary to the Minister of State for Health, Department of Health and Social Security
Mr A. R. MICHAEL, Second Secretary, Permanent Mission of the United Kingdom to the United Nations Office and the Other International Organizations at Geneva
Mr R. W. KYLES, Third Secretary, Permanent Mission of the United Kingdom to the United Nations Office and the Other International Organizations at Geneva

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Delegates
Dr A. CHIDUO, Minister of Health (Chief Delegate)
Mr W. MAKANE, Minister for Health, Zanzibar (Deputy Chief Delegate)
Dr W. K. CHAGULA, Ambassador Extraordinary and Plenipotentiary, Permanent Representative of the United Republic of Tanzania to the United Nations Office at Geneva

Alternates
Dr A. Y. MGENI, Director, Preventive and Promotive Health Services, Ministry of Health
Professor W. MAKENE, Dean, Faculty of Medicine, University of Dar es Salaam
Dr M. I. HASSAN, Director of Health Services, Ministry of Health
Mr S. J. ASMAN, Counsellor, Permanent Mission of the United Republic of Tanzania to the United Nations Office at Geneva

UNITED STATES OF AMERICA

Delegates
Dr C. E. KOOP, Surgeon General of the United States Public Health Service and Director, Office of International Health, Department of Health and Human Services (Chief Delegate)
Mr G. P. CARMEN, Ambassador, United States Permanent Representative to the United Nations Office and the Other International Organizations at Geneva (Deputy Chief Delegate)
Dr T. E. MALONE, Deputy Director, National Institutes of Health, Department of Health and Human Services

Alternates
Dr J. O. MASON, Director, Centers for Disease Control, Department of Health and Human Services
Mr N. A. BOYER, Director for Health and Narcotics Programs, Bureau of International Organization Affairs, Department of State

Advisers
Mr W. C. BARTLEY, International Health Attaché, United States Permanent Mission to the United Nations Office and the Other International Organizations at Geneva
Miss R. BELMONT, Associate Director for Multilateral Programs, Office of International Health, Department of Health and Human Services
Dr R. GRAHAM, Administrator, Health Resources and Services Administration, Department of Health and Human Services
Dr S. L. NIGHTINGALE, Associate Commissioner for Health Affairs, Food and Drug Administration, Department of Health and Human Services

Delegates
Mr A. S. KABORE, Minister of Public Health (Chief Delegate)
Dr M. SOME, Director of Public Health, Ministry of Public Health
Dr A. OEDERAOO, Director of Professional Training and Probation, Ministry of Public Health

UPPER VOLTA

Delegates
Mr L. A. GIVOGRE, Minister of Public Health (Chief Delegate)

URUGUAY
Delegates
Dr L. H. MANZANILLA, Minister of Health and Social Welfare (Chief Delegate)
Dr F. E. BELLO, Director General of Health, Ministry of Health and Social Welfare
Mr A. LÓPEZ OLIVER, Ambassador, Permanent Representative of the Republic of Venezuela to the United Nations Office and the Other International Organizations at Geneva

Alternate
Dr Maria-Esperanza RUESTÁ DE FURTER, First Secretary, Permanent Mission of the Republic of Venezuela to the United Nations Office and the Other International Organizations at Geneva

Advisor
Dr H. SUÁREZ, First Secretary, Permanent Mission of the Republic of Venezuela to the United Nations Office and the Other International Organizations at Geneva

Delegates
Mr NGUYEN DUY CUONG, Vice-Minister of Health (Chief Delegate)
Professor TRƯƠNG CONG TRUNG, Rector, School of Medicine, Ho Chi Minh City
Dr NGUYEN VAN DONG, Deputy Director, Department of International Relations, Ministry of Health

Alternates
Mr D. BOBAREVIĆ, Head of the Group for International Cooperation in the Field of Health and Social Welfare, Federal Committee for Labour, Health and Social Welfare

Delegates
Dr H. MAY SÓNORA, Director of Medical Services for Montevideo, Ministry of Public Health
Dr J. MEYER-LONG, Second Secretary, Permanent Mission of Uruguay to the United Nations Office and the Specialized Agencies at Geneva

VENEZUELA

Delegates
Mr K. AL-SAKKA, Director, Department of International Health Relations, Ministry of Health
Dr A. W. AL-GORBANI, Director, Yemeni-Swedish Centre, Ministry of Health

Alternate
Mr H. M. AL-MAGBALY, Ambassador, Permanent Representative of the Yemen Arab Republic to the United Nations Office at Geneva and the Specialized Agencies in Europe
Dr A. AL-HAMMAMI, Director-General of Medical and Health Services, Ministry of Health

Advisors
Mrs CHAU HOI NGO, Second Secretary, Permanent Mission of the Socialist Republic of Viet Nam to the United Nations Office and the Other International Organizations at Geneva
Mr VU HUY TAN, Third Secretary, Permanent Mission of the Socialist Republic of Viet Nam to the United Nations Office and the Other International Organizations at Geneva

YUGOSLAVIA

Delegates
Professor D. JAKOVLEVIĆ, Member of the Federal Executive Council; President of the Federal Committee for Labour, Health and Social Welfare (Chief Delegate)
Mr K. VIDAS, Ambassador, Permanent Representative of the Socialist Federal Republic of Yugoslavia to the United Nations Office and the International Organizations at Geneva (Deputy Chief Delegate)
Dr M. RADMILOVIĆ, Member of the Executive Council of the Assembly of the Socialist Republic of Croatia; President of the Committee for Health and Social Welfare of the Socialist Republic of Croatia

Alternates
Mr D. BOBAREVIĆ, Head of the Group for International Cooperation in the Field of Health and Social Welfare, Federal Committee for Labour, Health and Social Welfare

VIET NAM

Delegates
Mr NGUYEN DUY CUONG, Vice-Minister of Health (Chief Delegate)
Professor TRƯƠNG CONG TRUNG, Rector, School of Medicine, Ho Chi Minh City
Dr NGUYEN VAN DONG, Deputy Director, Department of International Relations, Ministry of Health

YEMEN

Delegates
Dr M. AL-KABAB, Minister of Health (Chief Delegate)
Mr H. M. AL-MAGBALY, Ambassador, Permanent Representative of the Yemen Arab Republic to the United Nations Office at Geneva and the Specialized Agencies in Europe
Dr A. AL-HAMMAMI, Director-General of Medical and Health Services, Ministry of Health

Alternate
Mr K. AL-SAKKA, Director, Department of International Health Relations, Ministry of Health
Dr A. W. AL-GORBANI, Director, Yemeni-Swedish Centre, Ministry of Health

Advisor
Dr H. SUÁREZ, First Secretary, Permanent Mission of the Republic of Venezuela to the United Nations Office and the Other International Organizations at Geneva

ZAIRE

Delegates
Dr M. TSHIBASSU, Commissioner of State for Public Health (Chief Delegate)
MEMBERSHIP OF THE HEALTH ASSEMBLY

Mr K.-N. MUKAMBA, Ambassador, Permanent Representative of the Republic of Zaire to the United Nations Office at Geneva and the Specialized Agencies in Switzerland (Deputy Chief Delegate)

Dr R. KALISA, Principal Adviser, Office of the Commissioner of State for Public Health

Alternates

Dr K. KABAMBA NKAMANY, Director, National Centre for Human Nutrition Planning, Department of Public Health

Mr F. B. KIBIKONDA, National Director of Pharmacies, Drugs and Laboratories, Department of Public Health

Mrs E. ESAKI-KABEYA, First Secretary, Permanent Mission of the Republic of Zaire to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

Mr G. OSIL, Second Secretary, Permanent Mission of the Republic of Zaire to the United Nations Office at Geneva and the Specialized Agencies in Switzerland

ZAMBIA

Delegates

Mr M. M. TAMBATAMBA, Minister of Health (Chief Delegate)

Dr E. K. NJELESANI, Director of Medical Services, Ministry of Health

Mrs H. K. MATANDA, Chief Nursing Officer, Ministry of Health

ZIMBABWE

Delegates

Dr S. T. SEKERAMAYI, Minister of Health (Chief Delegate)

Dr O. S. CHIDEDE, Secretary for Health, Ministry of Health (Deputy Chief Delegate)

Dr Doris HOLLANDER, Deputy Secretary, Mental Health and Psychiatric Services, Ministry of Health

Alternate

Dr Rose J. NDLOVU, Health Training Coordinator, Ministry of Health

REPRESENTATIVES OF AN ASSOCIATE MEMBER

NAMIBIA

Mr G. TOWO-ATANGANA, Counsellor, United Nations Council for Namibia

Dr I. INDONGO, Secretary for Health and Social Welfare

Mrs K. GARVEY-MWAZI, Programme Management Officer, United Nations Council for Namibia

KIRIBATI1

Mr B. TETAeka, Minister of Health and Family Planning

Mr P. T. TIMEON, Senior Assistant Secretary, Ministry of Foreign Affairs

1 Admitted to full membership of WHO, subject to deposit of an official instrument of acceptance of the Constitution with the Secretary-General of the United Nations (resolution WHA37.2).
THIRTY-SEVENTH WORLD HEALTH ASSEMBLY

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Permanent Mission of the Holy See to the
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Dr J. BONNEMAIN, Permanent Mission of the
Holy See to the United Nations Office and
the Specialized Agencies at Geneva

ORDER OF MALTA

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of the Sovereign Order of Malta to the
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Order of Malta

Count E. DECAZES, Ambassador, Deputy
Permanent Delegate of the Sovereign Order
of Malta to the International
Organizations at Geneva

Mr R. VILLARD DE THOIRE, Counsellor,
Permanent Delegation of the Sovereign
Order of Malta to the International
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Professor J. LANGUILLON, Technical Adviser,
International Committee of the Sovereign
Order of Malta for Aid to Leprosy Victims

Dr C. R. FEDELE, Technical Legal Adviser,
Permanent Delegation of the Sovereign
Order of Malta to the International
Organizations at Geneva

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PALESTINE LIBERATION ORGANIZATION

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Red Crescent Society

MR. N. RAMLAOUI, Permanent Observer of the
Palestine Liberation Organization to the
United Nations Office at Geneva

Dr A. BASHIR

Miss H. AYOUBI

Mr R. KHOURI

PAN AFRICANIST CONGRESS OF AZANIA

Mr S. SIMANI, Chief Coordinator of Medical
Services

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 T. IONESCU (Chairman)

Dr SOEJOGA

Dr Madiou TOURÉ
MEMBERSHIP OF THE HEALTH ASSEMBLY

REPRESENTATIVES OF THE UNITED NATIONS AND RELATED ORGANIZATIONS

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Mr T. S. ZOUPANOS, Deputy to the Director of External Relations and Inter-Agency Affairs
Mr V. LISSITSKY, External Relations and Inter-Agency Affairs Officer
Mrs A. DJERMAKOYE, External Relations and Inter-Agency Affairs Officer
Mr H. ANSAR-KHAN, Senior Liaison Officer, Centre against Apartheid, Geneva
Dr E. OTEIZA, Director, United Nations Research Institute for Social Development
Mr R. SOURIA, Senior Coordination Officer, Office of the United Nations Disaster Relief Co-ordinator
Mr R. LEIGH, Programme Policy and Evaluation Officer, United Nations Volunteers Programme
Mr J. PACE, Chief, Special Procedures Unit, Centre for Human Rights, Geneva
Mr A. H. GAHAM, Human Rights Officer, Centre for Human Rights, Geneva
Mr I. BITTER, Centre for Human Rights, Geneva

United Nations Children's Fund

Mr I. D. FALL, Chief, Policy and Programme Support Services, UNICEF Office for Europe
Mrs M. L. CARDWELL, Reports Officer, Policy and Programme Support Services, UNICEF Office for Europe
Mr R. GOODALL, Adviser, Essential Drugs Section, Division of Programme Development and Planning, UNICEF Headquarters, New York

United Nations Relief and Works Agency for Palestine Refugees in the Near East

Dr H. J. H. HIDDLESTONE, Director of Health and WHO Programme Coordinator

United Nations Development Programme

Mr P. BOURGOIS, Assistant Administrator of UNDP and Director, European Office
Mr I. HOLMSTRÖM, Senior External Relations Officer, UNDP European Office

United Nations Environment Programme

Dr L. PIEKARSKI

United Nations Conference on Trade and Development

Ms A. VON WARTENSLEBEN, Chief, Advisory Service on Transfer of Technology, Technology Division

United Nations Industrial Development Organization

Mr S.-P. PADOLECCHIA, Assistant to the Special Representative of the Executive Director at Geneva
Mrs A. TCHEKNAVORIAN-ASENBAUER, Chief, Pharmaceutical Industries Unit, Chemical Industries Branch

United Nations Fund for Drug Abuse Control

Mr H. EMBLAD, Assistant Executive Director

United Nations Fund for Population Activities

Mr B. MUNTASSER, Principal Liaison Officer, Geneva Office
Mr P. SCHATZER, External Relations Officer, Geneva Office
Mr G. PÉREZ ARGÜELLO, Associate Liaison Officer, Geneva Office

Office of the United Nations High Commissioner for Refugees

Mr A. J. F. SIMMANCE, Deputy Director, Assistance Division
Mrs G. SAGARRA, Technical Inter-Agency Cooperation Officer, Assistance Division

International Labour Organisation

Dr M. MOKRANE, Occupational Safety and Health Branch
Mrs A. SETH-MANI, Office of the Adviser for Inter-Organization Affairs
Mr A. LAHLLOU, Regional Office for Arab States

Food and Agriculture Organization of the United Nations

Mr S. AKBIL, FAO Representative to the United Nations Organizations in Geneva
Miss B. M. JENNINGS, Office of the FAO Representative to the United Nations Organizations in Geneva
<table>
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<tr>
<th>United Nations Educational, Scientific and Cultural Organization</th>
<th>World Intellectual Property Organization</th>
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<tr>
<td>Mrs J. WYNTER, Head, UNESCO Liaison Office in Geneva</td>
<td>Mr A. ILARDI, Senior Legal Officer,</td>
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<tr>
<td>Mr M. A. DIAS, Director, Division of Higher Education and Staff Training</td>
<td>Industrial Property Law Section,</td>
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<td>Industrial Property Division</td>
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<td>International Bank for Reconstruction and Development (World Bank)</td>
<td>International Atomic Energy Agency</td>
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<td>Mr L. P. CHATENAY, World Bank Representative to United Nations Organizations, Geneva</td>
<td>Mrs M. S. OPELZ, Head, IAEA Office in Geneva</td>
</tr>
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<td>Miss A. WEBSTER, IAEA Office in Geneva</td>
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<th>Commission of European Communities</th>
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<tr>
<td>Mr C. DUFOUR, Attaché, Permanent Delegation of the Commission of the European Communities to the United Nations Office and the Other International Organizations at Geneva</td>
<td>Mr M. EL-MAY, Ambassador, Permanent Observer for the League of Arab States to the United Nations Office at Geneva</td>
</tr>
<tr>
<td>Mr J. P. DERISBOURG</td>
<td>Dr F. EL-GERBI, Director, Department of Health and Environmental Protection, Arab League, Tunis</td>
</tr>
<tr>
<td></td>
<td>Dr B. SAMARA, Department of Health and Environmental Protection, Arab League, Tunis</td>
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<td>Mr O. EL-HAJJE, Attaché (Legal and Social Affairs), Permanent Delegation of the League of Arab States to the United Nations Office at Geneva</td>
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<td>Mr A. S. BEN HADID, First Secretary (Information and Cultural Affairs), Permanent Delegation of the League of Arab States to the United Nations Office at Geneva</td>
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<td>Mr A. ALAIMI, League of Arab States, Tunis</td>
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<td>Mr L. ALLOUAN, Ambassador, Assistant Secretary-General</td>
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<td>Mr M. MALHOUTRA</td>
<td>Dr O. MUNTASER, Ambassador, Permanent Observer of the Organization of African Unity to the United Nations Office at Geneva</td>
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<td>Mr K. G. MATHER</td>
<td>Dr M. RAJABALLY, Director, Health and Nutrition Division</td>
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<td>Miss D. RAMASAWMY, Counsellor, Permanent Delegation of the Organization of African Unity to the United Nations Office at Geneva</td>
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<td>Mr H. HABENICHT, Chief, Department of Planning, Liaison and Research</td>
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Dr J. A. BOSWICK
Professor G. DOGO

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Dr L. SÁNCHEZ MEDAL

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Dr Monique GOVAERTS
Professor L. ROCHE

World Federation of Hemophilia
Dr Lili FÜLÖP-ASZÓDI
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OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President:
Dr G. SOBERÓN ACEVEDO (Mexico)

Vice-Presidents:
Mr M. P. TO VADEK (Papua New Guinea)
Dr S. H. ALWASH (Iraq)
Dr M. SHAMSUL HAQ (Bangladesh)
Mr P. D. BOUSSOUKOU-BOUMBA (Congo)
Dr A. GRECH (Malta)

Secretary:
Dr H. MAHLER, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Argentina, Egypt, Ghana, Guyana, Iceland, Indonesia, Ireland, Jordan, Malaysia, Poland, Rwanda, Senegal.

Chairman: Mr E. G. TANOH (Ghana)
Vice-Chairman: Mr TAN Koon San (Malaysia)
Rapporteur: Mr A. GRÍMSSON (Iceland)
Secretary: Mr D. DEVLIN, Office of the Legal Counsel

Committee on Nominations

The Committee on Nominations was composed of delegates of the following Member States: Benin, Bulgaria, Burma, China, Costa Rica, Djibouti, Equatorial Guinea, Ethiopia, France, Jamaica, Japan, Mongolia, Nigeria, Peru, Sweden, Syrian Arab Republic, Tunisia, Union of Soviet Socialist Republics, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United States of America, Upper Volta, Venezuela, Zimbabwe.

Chairman: Dr O. S. CHIDEDE (Zimbabwe)
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: Botswana, Cameroon, Chile, China, Cuba, France, India, Kenya, Kuwait, Nigeria, Union of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, United States of America, Uruguay, Yemen, Zimbabwe.

Chairman: Dr G. SOBERÓN ACEVEDO (Mexico), 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: Dr K. AL- AJLOUNI (Jordan)
Vice-Chairmen: Mr R. EDWARDS (Canada) and Professor F. RENGBER (German Democratic Republic)
Rapporteur: Mrs K. M. MAKHWADE (Botswana)
Secretary: Dr D. K. RAY, Scientist, Health Manpower Planning

Committee B

Chairman: Dr N. ROSDAHL (Denmark)
Vice-Chairmen: Dr E. YACOUB (Bahrain) and Dr B. P. KEAN (Australia)
Rapporteur: Dr Sriati DA COSTA (Indonesia)
Secretary: Mr I. CHRISTENSEN, Administrative Officer
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