THE ADMINISTRATIVE ASPECTS OF THE WORLD HEALTH ORGANIZATION A STUDY IN DECENTRALIZATION

BY

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THE WORLD HEALTH ORGANIZATION

SIMAAN

To the Promoters of Health Standards

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INTRODUCTION

Dr. C.E.A. Winslow explicitly stated that:

> There is no area of human activity in which it is easy to obtain international cooperation as in the war against disease. The necessity for global organization is here most obvious since the germs of Plague and Yellow Fever ask for no passports. Furthermore the formation of a common front in this case calls for only minor sacrifices of the attributes of sovereignty and relatively slight interference with the vested interests of individuals.[1]

Epidemics do not respect physical boundaries but transcend national frontiers spreading persistant menace. The transmission of disease will spread over large areas especially when the existing ecological conditions are favorable and conducive. History witnesses numerous instances when pestilantial diseases have spread from their original place to neighboring adjacent areas. This phenomenon enhanced the establishment of a cooperative endeavor on an international basis to combat and control the spread of disease. The necessity for an international health

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[1] D.S. Cleever and H.F. Haviland, Organizing for Peace, (Massachussets: The Riberside Press, 1954), P. 116.

institute became obvious to all countries basically to restrict the spread of infection and contagious diseases and take the necessary medical precautions.

"Sincere men made ageless and earnest endeavors to lessen the insecurity of international life through the creation of institutions designed to bring some measure of political, economic, and social stability."[2] The persistant longing for peace, the continuous search for alternatives to the use of force and coercion as a means for redressing grievances and settling disputes, and the need to ameliorate the aggravated economic and social conditions of the world due to depressions, war devastations and disease, insinuated nations to participate and contribute to the various types of international organizations.

The major objective for the establishment of the various types of the international organizations was mainly to preserve political and national security on the one hand and economic prosperity and social welfare on the other.

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[2]Stephan S. Goodspeed, The Nature and Function of International Organization (New York: Oxford University Press, 1959), P. vii.

> International organizations began to develop to meet two separate needs: First, a general desire for peace and the growth of powerful relations. Second, a series of precise and limited objectives to meet specific cases. The former requires one international organization in principal universal in scope and objective and the latter can be met through several different organizations roughly classified under the economic, technical, social, humanitarian, military and political.[3]

However the growth in the number, size, and complexity of international organizations, and particularly the increase in the number and importance of public institutions since the formation of the United Nations System, focuses our attention upon the study and analysis of such institutions known as the Specialized Agencies or Functional Organizations.

The Economic and Social Council of the United Nations, appointed a standing committee on February 16, 1946 to negotiate agreements with the United Nations, subject to the approval of the Assembly, for the establishment of Specialized Agencies responsible and accountable to the Council and have harmonious

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[3] Paul Reuter, International Institutions (London: Purnell and Sons Ltd., 1958), P. 205.

relationships with the United Nations system. Ten Specialized Agencies, of which the World Health Organization is one, were set-up as shown in Chart I.

Article 57 of the United Nations Charter stipulates "That the specific social and economic activities of the United Nations are mainly handled on a decentralized and functional basis through ad hoc Intergovernmental organizations which are to be brought into relationship with United Nations and thereafter referred to as Specialized Agencies."[4]

The Specialized Agencies were assigned to operate outside the United Nations framework and are endowed with wide international responsibilities in the economic, social, cultural, educational, health, and relevant fields. Thus a decentralized system was established by the United Nations Charter whereby the Specialized Agencies will perform certain functions in the economic and social field, and the overall process of coordination will be accomplished by the Economic and Social Council of the United Nations.

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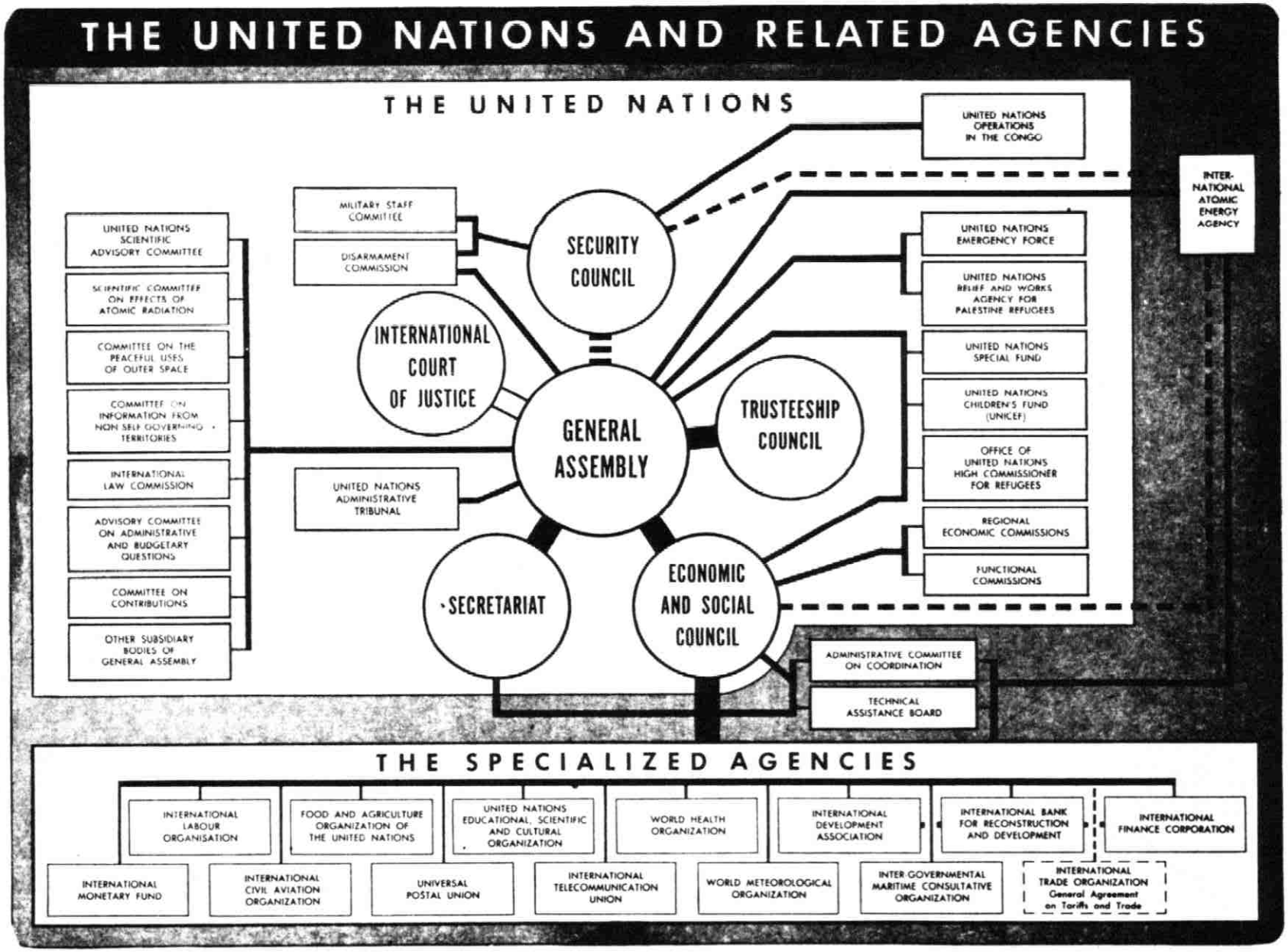
[4]Hossein Fakher, The Relationships among the Principle Organs of the United Nations (London: Staples Press, 1951), P. 80.



United Nations, Yearbook of the United Nations (New York: United Nations Office of Public Information, 1960), P. vi.

However, several underlying reasons stimulated the United Nations to adopt and implement a decentralized policy by conferring certain functions in the economic and social field upon the Specialized Agencies.

The assumption of the full burden by the United Nations is not advisable; such a policy will increase the size and complexity of the organization and consequently might produce unfavourable results. Moreover the concentration of responsibility and decision making powers pertaining to all fields of competence conducted by the United Nations, will be adversely viewed by its members, who fear the inefficient execution of the burden of work due to the multiplicity of the functions and complexity of work. The high degree of specialization needed and the technical nature of the work to be done in the economic and social field, necessitated the practising of the policy of delegation of powers to small specialized units staffed by skilled technicians and experts. Furthermore, the pressing need for a sound administrative apparatus and the necessity for the performance of certain administrative functions stimulated the implementation of the process of delegation of powers to the Specialized Agencies which are administrative and functional in nature.

Similarly, the functional nature of the Specialized Agencies provided an opportunity for greater concentration and meticulous tackling of the economic and social problems encountered. This attempt isolated the Specialized Agencies from the political atmosphere haunting the United Nations and inhibited them in a free environment secluded from the political manoeuvers and devoted to meet the increasing social and economic demands of the age.

The general nature of the Specialized Agencies shows the close resemblance existing between them and depicts their common characteristics. The Agencies owe their legal existance to treaties or agreements concluded between member states and eligibility for membership is provisioned by the adherance of the members to the specific terms of the constituent charters of the Agencies. The constitution or charter of each of the Specialized Agencies, defines the duties and responsibilities, creates the structure of the organization, and provides the necessary officials and staff for the supervision and administration of the work of the agency. Each of the Agencies has an independent budget which is primarily financed by contributions from member states. More specifically, each has the same organizational structure namely an Assembly or Conference, an Executive Council,

Board, or Committee and a Director-General or Secretary General. Moreover, each has its Secretariat, independently recruited, and its Headquarters. "None of the Specialized Agencies can do more than propose legislation to their members. Draft treaties are prepared which can become a portion of the domestic law of member states only if the treaties are ratified."[5]

The Administrative Committee on Coordination affiliated to the Economic and Social Council is composed of the heads of the Specialized Agencies. The major functions of the Committee is to coordinate the functions of the Specialized Agencies and avoid any overlapping and duplication of work.

"While the general outlines of the Specialized Agencies are similar, they vary in their organizational features and practices designed to fit their individual needs and functions."[6]

In one respect, the Specialized Agencies possess special roles in the economic and social field devoted to

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[5] Goodspeed, Op. cit., PP. 399 - 400

[6] Ibid., P. 403.

social progress and welfare, and economic development and prosperity. However, each agency has its particular responsibility, unique problems, and definite procedures for the attainment of the goals.

Any international organization irrespective of its nature, cannot be comprehended unless we describe and evaluate its structure and functions. Furthermore, every international organization is confronted with new conditions, hindrances, and a quest for change which needs continuous adaptation and adjustment. Thus it is appropriate to pinpoint the major issues, the gradual trends, evolutionary progress, and the failures or success of its operations.

> In order to understand the general features of the Specialized Agencies and the full scope and nature of the World Health Organization, it is useful to examine it in detail to learn the nature of its functions, structure, and organization and to discover the range of its activities, the problems encountered in program-making and implementation, and various questions of administration which have an important bearing upon international organization in general.[7]

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[7] Ibid., P. 404

The ingredients of this study on "The Administrative Aspects of the World Health Organization," is in fact an attempt to analyze the administrative process of the Agency, to expound on the manner in which it executes its programs by means of its unique regional arrangements in the international field, and to evaluate the effect of its structural set-up and the procedures and policies adopted on the work flow of the organization. The World Health Organization, a specialized agency of the United Nations, deserves a special attention and assessment due to the sharp difference from the other specialized agencies in implementing its programs and decisions on a world wide functional and geographical decentralized basis. The Organization has sought to apply the principle of decentralization to its operating programs by conferring commensurated authority and responsibility upon the regional organizations and thus making its work more responsible and diversified. The remarkable progress attained by the Agency in the short period since its emergence, the significant contributions to the welfare of mankind, and the marked difference from the other similar international organizations in the systematic execution of its functions and successful conduct of its operations make it worthwhile to examine the experience of the World Health Organization.

However, the international feature of the organization and the vastness of the field of competence in which the organization functions imposes numerous limitations on the study. The World Health Organization has universal implications in the sense that it has sacred obligations to all people of the world in the economic and social field in general and in the field of public health in particular. Thus a detailed tackling of all the phases of the Organization will lead to an inadequate bulk of the study and might not result in a comprehensive and coherent work. Furthermore, the technicalities involved in the field of health and the specialized and precise knowledge required imposes on the study a complete disregard of the health aspects of the Organization.

Finally, the unorganized literature and the scanty research done on the agency, makes the sources of information a serious detriment to the scope of the study.

The remainder of the study shall comprise of the following sections:

Chapter Two will present a general view of the World Health Organization indicating its historical background,

organizational structure and the scope of the services and functions encompassed by the Agency.

Chapter Three tackles mainly the impact of the administrative theory of decentralization as applied by the World Health Organization. The process of implementing effectively a decentralized coordinated program with the arguments for and against the theory of decentralization in the Agency will be presented. Further, the impact of the social and political tendencies on the work of the Agency will be stressed.

The Fourth Chapter traces the financial policy of the Agency. A survey of the budget cycle, as to the basis and sources of finance, preparation, execution and appropriation of the budget. That Chapter will also reveal the extent and efficacy of decentralizing the budget process. Further, enumeration and elaboration on the budgetary problems will be made.

Chapters Five and Six deal with the personnel policies and staff development of the World Health Organization. An exposition of the phases comprising the personnel system and the problems involved will be surveyed.

Finally, Chapter Seven, will present a general assessment and evaluation of the Agency, in the light of the material presented in the text of the study.

The Importance of the Study

The importance of the study is attributed to the increasing attention awarded by the field of Public Administration to the field of International Administration. Despite the fact that the literature and research done on international administration is still scarce and unorganized, yet the significant experience and contributions of other international agencies to the field of administration, provides the raw material and a useful framework for further probing into an interesting and unexplored area in administration.

Donald C. Stone known in the fields of both national and international administration declared, "I have found no support for the contention that international administration is fundementally different in nature from any other kind of administration."[8]

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[8] Donald C. Stone, "An Application of Scientific Management Principles to International Administration", American Political Science Review, XXXX (October, 1948), P. 915.

> The growing complexity of governmental processes, resulting to a great extent from the taking over by governments of functions which were formerly considered outside their area of competence, leads to serious concern with the implications of Big Government. This concern with the problem of "Bigness" in government has, in many national administrations, produced strong movements to reverse the prevailing trend, to make administration more responsible to the individual and local community. This "Localization of administration led for a greater participation of citizens in the processes of government.[9]

At the international level, despite the recent origin of the institutions, however, the growing importance and membership of the international organizations has aroused the concern of national governments and world public. It was remarked that "Since the machinary of international organizations is less developed than that of national governments, administrative control within the former is generally less direct than the latter."[10]

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[9]Robert Berkov, The World Health Organization: A Study in Decentralized International Administration (Geneva: Librairie E. Droz, 1957), P. 4.

[10]Norman L. Hill, International Administration (New York: McGraw-Hill Book Co. Inc., 1931), P. vii.

Nevertheless, the problems posed by the coordination of huge complex organizations operating on a world wide basis stimulates the need for more information and analysis of the administrative machinary of such organizations. Moreover, an analysis of the organization and management aspects of the organization provide a useful data for further poking into this subject and a chance for developing theories of international organization and management. The policy of decentralization which the World Health Organization has embarked upon, and the successful development of the policy of decentralization further than most of the contemporary international organizations adds to the importance of the study.

> The movement in industrial, economic, and social organization has been almost constantly toward larger units of responsibility. Not only have states and governments experienced this movement, but the organs of international cooperation have likewise reflected it. And some observers have contended that the integration of governmental power is merely a necessary concomitant of these economic and social changes.[11]

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[11] Berkov, Op. cit., P. 4.

Methods and Techniques

Despite the scarcity of material available on the World Health Organization, yet the contents of the study are derived from a variety of sources.

The official records and documents issued by the World Health Organization provide a basic and genuine source of information. Annual publications of the Director General on the work of the World Health Organization provide a broad picture and a general framework about the functions and structure of the organization. Moreover, the financial report, the reports of the Executive Board and the World Health Assembly, and the Handbook of Basic Documents of the Organization, give a profound source for the details and specifications of the work of the organization.

Books on international organizations survey the historical background of international cooperation and particularly the history of earlier international health organizations.

Articles in periodicals pertaining to the World Health Organization provide the analytical and evaluative aspect of the study with an emphasis on the problems encountered by the Organization.

Finally, interviews with Regional and area representatives of the World Health Organization and with the representative of the Organization to the UNRWA and with local health officials, provided a more profound insight and a guiding outlook on the operating methods and policies of the Organization.

Terminology

Although some of the concepts will be tackled and elaborated on later in the text of the study, yet, it may be useful and fruitful at the outset to clarify the basic terms and concepts and identify the reader with the recurrent terms.

A Specialized Agency:

> By a specialised agency is meant one which conducts a program of importance to the United Nations in a special field of competence, under the general review of the General Assembly and the Economic and Social Council, but with important scope in matters of membership, program, personnel and finance.[12]

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[12] Eugene P. Chase, The United Nations in Action (New York: McGraw-Hill Book Co. Inc., 1950), P. 248.

Decentralization:

> Refers to the establishment or extension of field machinary per se, to the outposting of headquarters personnel to existing field units, to the devolution of decision making authority as suggested above or to varying combinations thereof. Once in operation, to be sure, agency field offices tend to acquire discretionary functions either by explicit delegation from the center or by accretion through practice.[13]

Centralization:

> As the concentration of authority and responsibility for policy decisions in the chief executive officer and his immediate staff. While decentralization refers to the transfer, by delegation, of such authority from a higher to a lower, or subordinate, level of organization.[14]

Regionalization:

> Refers to the process of delineation of areas and establishment of regional organizations. The process of regionalization which is simply decentralization on geographic basis, preceeded the embarkment of the World Health Organization on applying a decentralized policy in performing its functions and activities.

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[13] Walter R. Sharp, Field Administration in the United Nations System, (New York: Stevans and Sons Limited, 1961), P. 508.

[14] Leonard D. White, "Decentralization", Encyclopedia of the Social Sciences, V, PP. 43 - 44.

CHAPTER II

THE STRUCTURAL ASPECTS OF THE WORLD HEALTH ORGANIZATION

Historical Background

In order to understand the significance of any organization and in particular the decentralized nature of the World Health Organization, it is of crucial importance to trace the historical evolution and development of the Organization in an attempt to survey its structure and operations and place them in their proper perspective.

International collaboration and action in the field of Public Health has been recognized since many years as the only feasible method for tackling the many problems of health and promote and protect the highest possible level of health. Consequently, a number of international health organizations were created before the United Nations System was established.

The need for combatting infectious diseases led national governments to establish health services and protective devices. However, the lack of similar health and sanitary measures in other countries led to a

widespread demand for international action and was prompted by the fact that there existed four international intergovernmental health organizations already functioning.

The Pan American Sanitary Bureau known as the Bureau, was established in Washington in 1902, to draft international sanitary conventions for the American region. The Bureau was functioning at the time when negotiations for the establishment of an International Health Organization were undergoing. The Bureau, a flourishing and an independent institution, constituted a real problem to the establishment of a single world wide health agency under the auspices of the United Nations. After considerable discussion and negotiations the Bureau was amalgamated with the World Health Organization as an integral part and operating as its Regional Office for the Americas.

The International Office d'Hydgiene Publique, known as the Office, was established by the Rome Agreement of 1907. The Office was situated at Paris and placed under the supervision of a Permanent Committee.

"The Office had two principal functions: To collect and disseminate information in regard to Public Health, and to supervise the application of the sanitary conventions. It was also assigned the task of preparing suggestions to modify the conventions."[1]

In 1950, the Office ceased to exist and the 1907 Agreement was denunciated. The remaining functions and property of the Office were transferred to the World Health Organization.

The Health Organization of the League of Nations was initially created as a Temporary Epidemics Commission in 1920. The League later sought to establish a Permanent Health Organization and envisaged to absorb or merge The International Office d'Hygiene Publique. But opposition from the members arose and consequently the Permanent Committee of the Office became the principle organ of the League Health Organization. The functions of the League Health Organization were notable for their emphasis on the assistance to nations with specific health problems. The United Nations in April 1946 assumed the health functions of the League and in October of the same year the functions and personnel

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[1]World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 17.

of the League were formally transferred to the World Health Organization.

Finally, the Health Work of the United Nations Relief and Rehabilitation Administration, known as UNRRA, was established in 1943 and its functions and responsibilities were partially assumed from the Office and the League. The primary functions of UNRRA were mainly to furnish medical and clinical services and supplies to countries devastated by wars, to send missions to combat specific diseases and circulate scientific publications.

> To carry out this work, UNRRA created an organization with greater regional ramifications than any of its predecessors, and also accompanied this regionalization with a high degree of true decentralization. The regional organization which the World Health Organization has later adopted owed much to the earlier experience of UNRRA, if it was not actually inspired by it.[2]

The numerous projects and services inaugurated by UNRRA were resumed by the Interim Commission of the World Health Organization.

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[2] L. Larry Leonard, International Organization (New York: McGraw-Hill Book Co., Inc., 1951), P. 461.

> The regional aspects of international health work had, however, an earlier origin, as has been indicated, in the first cooperative efforts toward international action in preventing the spread of disease from one region to another. And it was the institutionalization of these efforts which confronted the World Health Organization, at its very beginning with the practical necessity to make administrative arrangements for the continuation of such institutions.[3]

However, despite the fact that each of the Four Agencies contributed to the World Health Organization, yet none could satisfy the critical needs of the people in the field of health . Thus the necessity for a single world wide health system as embodied in the United Nations Charter, within the broad framework and under the auspicies of the United Nations, came to be recognized and felt as a pressing need to preserve the highest standards of health.

Origin

The origin and immediate motivation of the World Health Organization goes back before the United Nations system came into existance.

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[3] Robert Berkov, The World Health Organization: A Study in Decentralized International Administration (Geneva: Librairie E. Droz, 1957), P. 49.

"The critical period in the evolution of International Public Health came at a time when the governments and peoples of the world were not only animated by the will to rebuild world peace on firm foundations, but also confident that science would provide them with the means to do so."[4]

The idea that medicine is one of the pillars of peace prevailed in the minds of the delegates who attended the United Nations Conference on International Organization at San Fransisco in 1945. The San Fransisco Conference realized the vitality of health as an element for the promotion of the conditions of stability and well being. Hence the concept of health should be broadened, and the health of all people, as it has been embodied in the Constitution of the World Health Organization, is fundemental to the attainment of peace and security.

A joint resolution was submitted by the Brazillian and Chinese delegations to the Conference, recommending the holding of a Convention for the purpose of establishing an international health organization with the approval of the General Assembly of the United Nations. The joint declaration was unanimously approved by the San Fransisco Conference.

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[4]World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), PP. 37 - 38.

In the meantime, the Economic and Social Council was set up upon the ratification of the Charter of the United Nations. The council summoned for an International Health Conference and appointed a Technical Preparatory Committee composed of experts in the field of Public Health in order to draft proposals which are to be submitted to the International Health Conference.

The Conference convened in New York in June 1946, to study the proposals of the preparatory Committee and was composed of members and non-members of independent states in the United Nations, as well as observers from occupied territories and representatives from other Specialized Agencies. The Conference adopted a Constitution which was signed by 61 delegates, 51 of which were members of the United Nations and 10 were non-members. However, the Constitution was to enter into force upon its ratification by a simple majority of member states of the United Nations. In the meantime, an Interim Commission was established by the conference to assume the functions prescribed by the Constitution pending its ratification.

The interval preceeding the establishment of the World Health Organization represents the period in which

the Interim Commission functioned. The Interim Commission which was established on the 22nd day of July, 1946 was forced to extend its operations for nearly two years because of the delay in obtaining the necessary majority to ratify the Constitution. The Commission was empowered to appoint an Executive Security as the Chief Technical and Administrative Officer authorized to appoint a staff and incur provisional expenses. Finally, the Interim Commission would cease to exist upon a resolution by the First Health Assembly.

"The Interim Commission had therefore to undertake a number of activities which had not been foreseen at the New York Conference. It was led inevitably to adopt policies and methods of work which partly influenced the structure and growth of the organization in its early days."[5]

The operations of the Interim Commission were financed by funds from the United Nations and advances from governments in case of insufficiency. Concerning the personnel and administrative services of the Commission, it depended upon the United Nations and was guided by the United Nations precedents on the staff and financial regulations and procedures.

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[5] Ibid., P. 55.

A remarkable achievement of the Interim Commission was its advancement of the process of regionalization and consequently decentralization. The Commission proceeded to negotiate an agreement with the Pan American Sanitary Bureau for its amalgamation and integration with the World Health Organization and as such paved the way for the implementation of a policy of delineation of geographical areas which is a pattern of regionalization.

"The World Health Organization came into being as a permanent organization on September 1, 1948, after the requisite number of ratifications of the Constitution had been affected. The Interim Commission was thereupon dissolved, and the World Health Organization began its activities with the holding of the First World Health Assembly."[6]

Aims and Functions

The Constitution of the World Health Organization was drawn on the 22nd day of July, 1946, by the International Health Conference and was signed by sixty one member states. The Constitution depicts the main aims and functions of the Organization and indicates the scope and extent of its operations.

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[6]Berkov, Op.cit., P. 27.

The text of the Constitution can be referred to in Appendix A. The Preamble and Chapter I of the Constitution give a broad outlook of the general principles and the overall objective of the Organization, while Chapter Two explicitly expresses the broad functions encompassed by the World Health Organization. The contents of the remaining Seventeen Chapters will be dealt with under the related topics of this Chapter.

The Objective of the World Health Organization, as stipulated in Article I of Chapter I in the Constitution states as follows: 'The attainment by all peoples of the highest possible level of health', with health being defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. "The World Health Organization is to serve as the coordinating authority on international health work, to maintain certain necessary international services, to promote and conduct research in the field of health, and to promote imporved standards of teaching in the health, medical and related professions."[7]

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[7]Amry Vandenbosch and Willard N. Hogan, The United Nations: Background, Organization, Functions, Activities (New York: McGraw-Hill Book Co., Inc., 1952), P. 161.

The Preamble regards health as a generator of peace and security and the highest levels of health should be enjoyed without any distinction of race, religion, political inclinations and social or economic conditions.

The functions of the Organization which are enumerated in Article II of Chapter Two in the Constitution comprise a series of attempts to coordinate and direct national health activities and provide, assist and promote the health conditions of its members.

The Document, in its explicit exposition of principles and its bold conception of the aims and purposes of the new organization extended far beyond the hopes and aspirations of those who advocated for a single world wide health body and encompassed other fields of competence and sacred needs.

> The Constitution is remarkable for its breadth of vision. The vastness culminates in its implications of public health on the highest phases - to promote health, to prevent disease and to rehabilitate suffering. It visualizes the twentieth Century public health as being concerned with social factors, during and after the onset of illness - all disease, degenerative as well as infectious, mental and physical. It is keenly interested in handicaps and other infirmaties, it believes in health education and wants accurate records of morbidity and mortality and allied social phenomena.[8]

Membership

The Constitution in its Third Chapter which is comprised of Six Articles prescribes the rules and regulations governing the right for membership in the World Health Organization. Article Three stipulates that 'Membership in the Organization shall be open to all states'. All countries which are members of the United Nations are eligible to become members by accepting the Constitution. Non-members of the United Nations and the states whose governments sent observers to participate in the International Health Conference held in 1946, are entitled to be admitted as members by accepting the Constitution of the World Health Organization.

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[8] B.A. Wortley, The United Nations: The First Ten Years (London: Manchester University Press, 1957), P. 135.

The Constitution in Article 8 provides for membership to territories which are not responsible for the conduct of their international relations. These territories may be admitted as associate members by a resolution from the World Health Assembly, upon a submission of an application on behalf of the territory by a member state or other authority having responsibility for their international affairs. The Article adds that representatives of associate members to the Health Assembly should be technically qualified in the field of health and a national selected from the native population.

The extent and nature of the rights and obligations of associate members shall be determined by the Health Assembly. It resolves:

> Associate members may propose items for inclusion in the Assembly's Agenda, take part in all the Assembly's proceedings, but not vote or hold office either at plenary meetings or in the main and certain other important committees of the Assembly; Further they are not eligible to designate members of the Executive Board, but they may submit proposals to the Board and participate in committees established by it.[9]

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[9]World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 81

The evolutionary trend for the continuous increase in the membership of the World Health Organization as shown in Table 1, is an important indicator and a symptom of the progress and effectiveness of the Organization. Membership of the World Health Organization in accordance with its regional distribution for the year 1963, appears in Appendix B.

TABLE 1

MEMBERSHIP OF THE WORLD HEALTH ORGANIZATION

AS OF DECEMBER 1948 - 1963*

Year	No. of Members	No. of Associate Members
1948	56	-
1949	68	-
1950	73	1
1951	78	3
1952	79	3
1953	81	3
1954	81	3
1955	81	4
1956	84	4
1957	85	3
1958	85	3
1959	87	3
1960	97	4
1961	108	2
1962	114	1
1963	117	3

*World Health Organization, Handbook of Resolutions and Decisions of the World Health Assembly and the Executive Board (Geneva, 1948 - 1963).

Concerning the termination of membership, withdrawal is the most popular device resorted to by member states. However, the World Health Organization, does not provide for a withdrawal clause in its Constitution, but the power of suspension exist by virtue of Article 7 of the Constitution, which stipulates that 'If a member fails to meet his financial obligations to the Organization, or in other exceptional circumstances, the Health Assembly may, on such conditions as it thinks proper, suspend the voting privileges and services to which a member is entitled. The Health Assembly shall have the authority to restore such voting privileges and services'.

Thus the simple device of merely reciting failure of a member to discharge his financial obligations to the Organization, is a condition sufficient to warrant suspension.

"However, international practice in the case of the World Health Organization supports the contention that where there is no withdrawal clause, the right to withdraw ceases to exist."[10]

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[10]Nagendra Singh, Termination Of Membership Of International Organizations (London: Stevens & Sons Ltd., 1958), P. 89.

The Union of Soviet Socialist Republic and Ukranian SSR communicated their intention to withdraw from the World Health Organization in 1949. Subsequently, in 1950, Bulgaria, Albania, Czeckozlovakia and Rumenia communicated a similar intention. Since no withdrawal clause exists, the withdrawn members cannot be deemed, by law, to have withdrawn, and the Organization, therefore regarded them as having remained members liable for the payment of default subscriptions and other financial obligations. The states of the Communist Bloc were labled as inactive members but they intimated their intention to resume active participation, and in 1955 active participation was resumed as the Communist Bloc realized that international collaboration in the field of Health is indispensable and surmounts all political controversies and surpasses all ideological cleavages existing between member states of the World Health Organization.

Composition

The Constitution of the World Health Organization provides for the basic structure of the Agency which is composed of Three Organs designed to carry out the work of the Organization. These are namely:

1. The World Health Assembly (Known as the Health Assembly)

2. The Executive Board (Hereafter called the Board)

3. The Secretariat

The organizational structure of the World Health Organization appears in Chart II.

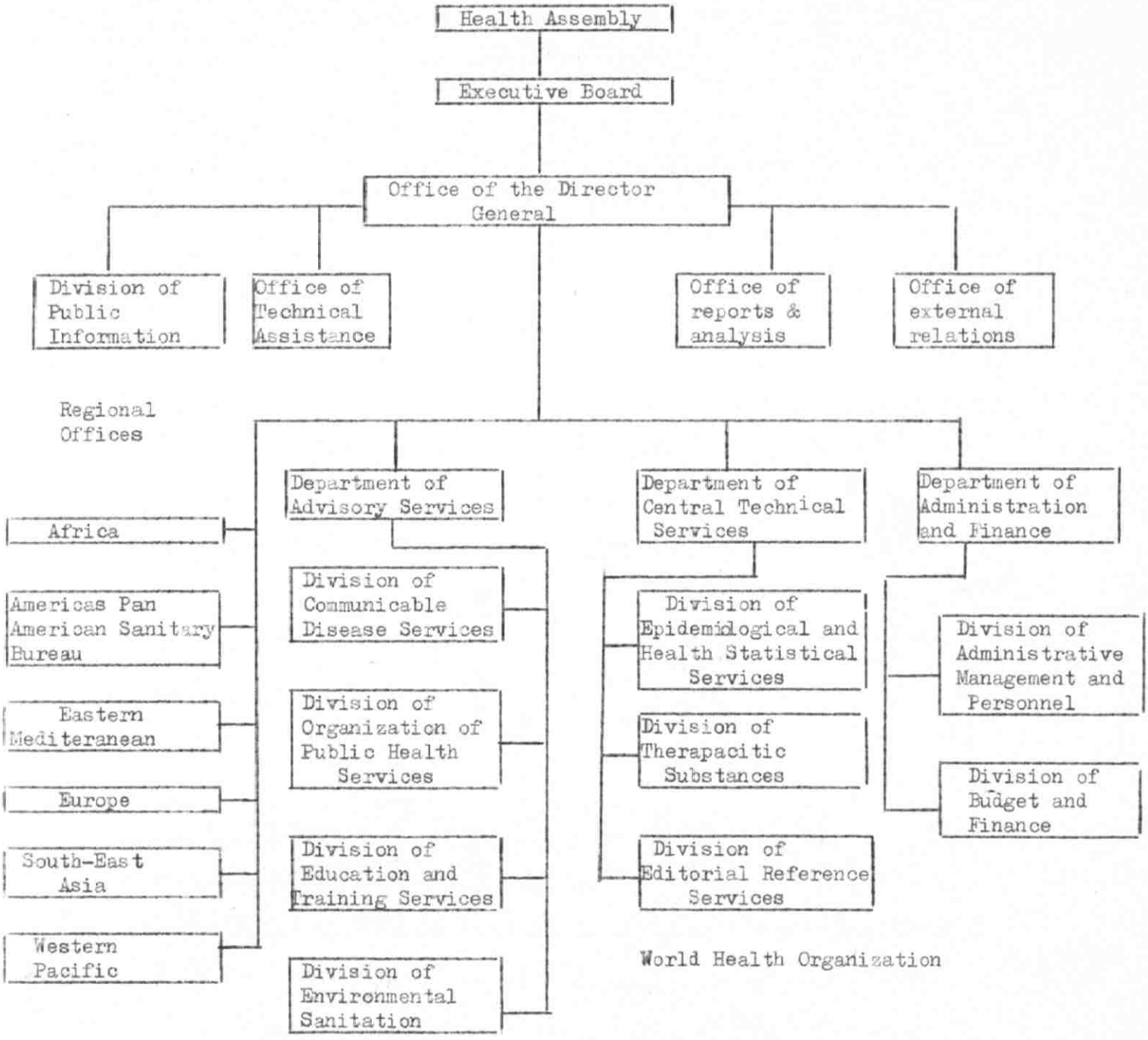
The World Health Assembly is the general legislative and policy making organ of the Organization. The Assembly was the first organ which was instituted by the Constitution to perform the work of the Organization in accordance with an adopted set rules of procedures and subject to the authority of the Constitution. However, in case of any conflict between any provision of the Constitution and the rules of procedures, the constitutional provisions will superseed and overrule. The Assembly and its subsidiary bodies are governed by hundred twenty rules of procedures.

The major functions of the Assembly are set forth, in Article 18 of the Constitution, and the most important are the following:

1. Determination of the policies of the Organization.
2. Designation of Board members.
3. Appointment of the Director General.
4. Promotion of research in the field of Public Health.

CHART II

ORGANIZATIONAL CHART OF THE WORLD HEALTH ORGANIZATION*



*Stephen S. Goodspeed, The Nature and Function of International Organization (New York: Oxford University Press, 1958), P.405.

5. The reports and activities of the Board and the Director-General are susceptible to the review and approval of the Assembly.
6. It acts as the supreme financial authority. It reviews and approves the budget and supervises the financial policies of the Organization.
7. Establishment of health institutions and setting up of necessary committees.

Article 11 of the Constitution of the World Health Organization stipulates that "Each member shall be represented by not more than three delegates, one of whom shall be designated as Chief delegate. These delegates should be chosen from among persons most qualified by their technical competence in the field of health, preferably representing the national health administration of the member."[11]

Delegates may accompany with them advisors. Furthermore, representatives of associate members, Executive Board members, United Nations members and other specialized agencies and intergovernmental organizations may attend but subject to limitations prescribed by the rules of proceedure governing the operations of the Assembly.

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[11]World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 5.

The official languages of the Assembly are Chinese, French, English, Spanish and Russian while its working languages are French and English.

The Assembly meets annually and convenes in special sessions when the need arises subject to the request of a majority of the members or the Executive Board.

The Assembly, at the annual session, selects the country in which the next session will be held. The Board determines the place of the special sessions. Concerning the date of the sessions, the Board consults with the Secretary General of the United Nations and fixes the time by a joint resolution. The President of the Assembly and the other officers are elected at the beginning of the annual session for a period of one year.

The Executive Board acts as the executive organ of the World Health Organization by effecting the policies and decisions of the Assembly and performs all the functions delegated by the Assembly. Fifty four rules of procedure govern the work of the Board.

The functions of the Board, as outlined in the Constitution, empowers it to advise and submit proposals

to the Assembly on its own initiative, prepares programs subject to the approval of the Assembly and authorizes the Director-General to initiate any action in emergency situations. The Board appoints the Regional Directors in consultation with the Regional Committees. It further examines the annual financial report and budget estimates, and convey its observations to the Assembly.

Members of the Board do not represent state members but are designated by them to serve as individuals. The Assembly elects members entitled to designate a person who is technically qualified in the field of health to serve on the Board. The Board consists of twenty four members who are elected for three years, while the term of one third of the members expires every year.

The Board convenes twice every year and fixes the place and time of each meeting. The Chairman of the Board is elected from the Board members by a simple majority vote.

The Secretariat is the third organ of the World Health Organization and is headed by the Director-General as the Chief Technical and Administrative Officer of the Organization.

The organizational structure of the Secretariat is shown in Chart III. The structure indicates the scope of operation of the Organization and includes officials and employees at the Headquarters, the Regional Offices, and at the field projects of the Organization. The Director-General is nominated by the Executive Board and appointed by action of the Health Assembly.

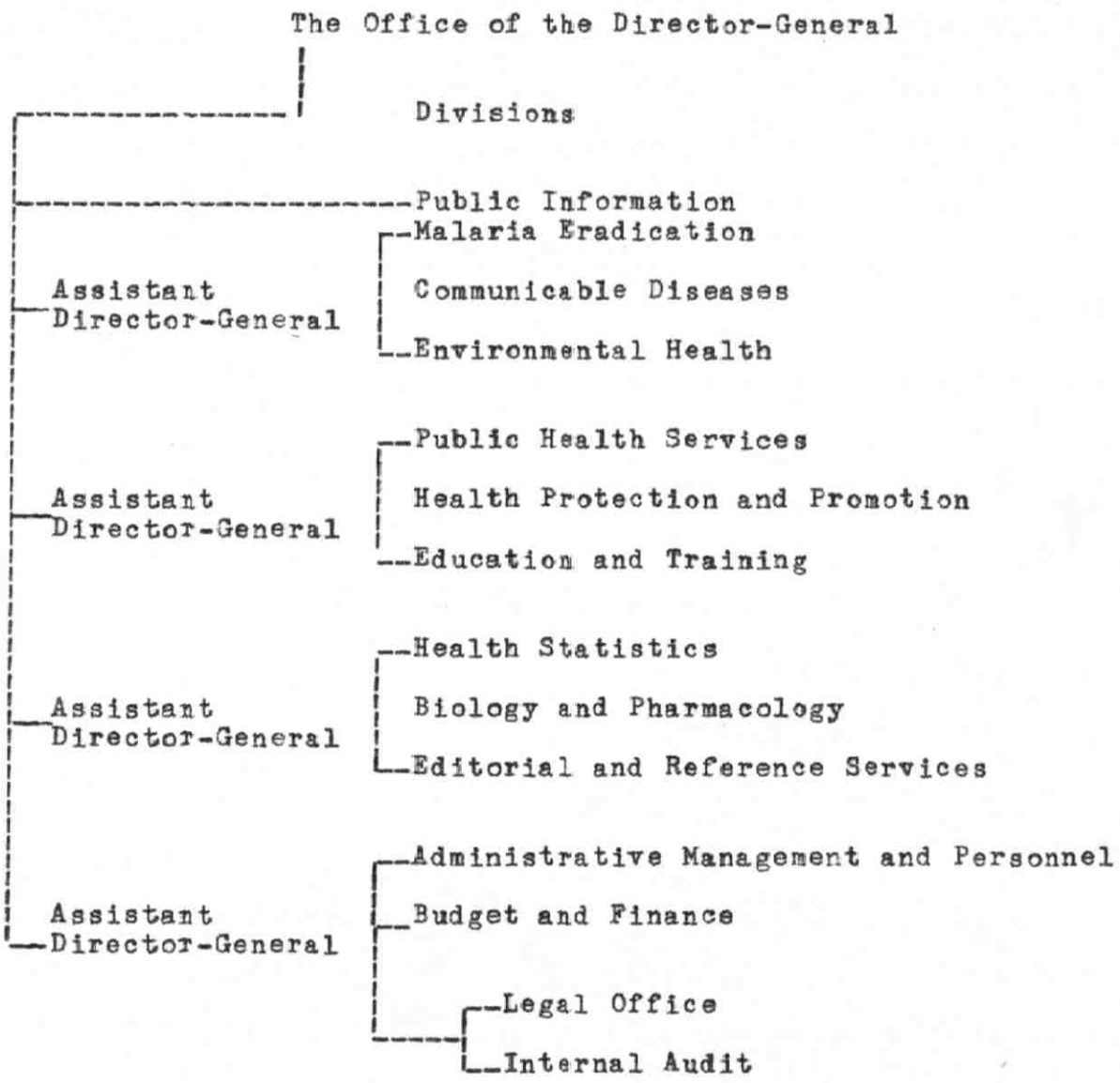
One of the principle duties of the Director-General as stipulated in Article Thirty Two of the Constitution, confers upon Him as the Ex-office Secretary of the Health Assembly, the Executive Board, and all committees, commissions and conventions of the Organization. However, delegation of the above duties is permissable.

By virtue of Article Thirty Three of the Constitution, the Director-General should prepare and submit annually to the Board the financial statements and budget estimates of the Organization.

The personnel aspect of the Secretariat is also the responsibility of the Director-General. He appoints the staff of the Secretariat in accordance with the staff regulations set by the Health Assembly. A paramount regard to the efficiency, integrity and international

CHART III

HEADQUARTERS SECRETARIAT OF THE WORLD HEALTH ORGANIZATION*



*Official Records of the World Health Organization, The Work of WHO: 1962 Annual Report of the Director General to the World Health Assembly and to the United Nations, No.123 (Geneva, 1963), P.179.

geographical representation of the staff of the Secretariat, is given due consideration in the process of appointment. Moreoever, conformity with the conditions of the staff of the United Nations should be maintained. The Director-General and the Staff shauld refrain from receiving any instructions from their national governments in order to avoid any prejudicial attitude or the jeopordize of the authority or discretionary powers enjoyed by the staff.

Finally, the Director-General is empowered to establish by agreement with the members, his own rules of procedure for the purpose of discharging his duties and have direct conceivable access to their departments. Furthermore, He may establish direct relations with other international organizations whose field of competence correspond with the activities of the World Health Organization.

The First Director-General of the World Health Organization was Dr. Brock Chisholm. Dr. M.G. Candau of Brazil succeeded Dr. Chisholm and presided over the Secretariat since 1953 and up till now.

Work

The Work of the World Health Organization which is carried out by the Secretariat can be classified into two broad types: The Technical Services and the Advisory Services. The services are rendered to national governments who are members in the Organization and governments who are non-members in time of crisis as a humaniterian gesture on the part of the World Health Organization.

In general, the work of the Organization and the responsibility of the Headquarters Secretariat constitute the following functions:

> Technical advice, stimulation and support of Regional Offices, coordination of Regional Programs, coordination of the programs of the World Health Organization with those of other agencies, evaluat ion of Regional Programs, establishment of standards, convocation of expert committees and transmission of information from their meetings, administration and interpretation of the International Sanitary Regulations, and the central control of internal audit and staff practices.[12]

The two types of activities are represented by separate departments, each headed by an Assistant Director-General. The Third type of activity is

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[12] Berkov, Op.cit., P. 87.

concerned with administrative services. The Department of Administrative Services is headed by an Assistant Director-General, but the realm of its activities does not transcend the boundaries of the World Health Organization.

The Central Technical Services form the information and fact gathering activity of the Organization and administers International Health Regulations which are initiated by the Health Assembly.

An International Warning System, formerly established by the League of Nations, was expanded by the Technical Service Department of the World Health Organization. The System is a daily service spread on a world wide scale by radio transmitters. A second contribution is a system of International Health Safeguards designed to provide the greatest protection to countries.

Another important function, is the continuous determination of standards of drugs and biological products. Universal drug standardization and uniformity of quarantine regulations to minimize the spread of infectious diseases is a prominant and intricate activity of the Technical Services rendered by the

World Health Organization. Moreover, the Agency succeeded in compiling a number of sanitary conventions as guidelines for the preservation of sound sanitary conditions.

An outstanding feature of the Technical Services lies in the dramatic assistance of the World Health Organization to all countries struck by calamities such as earthquakes, floods and outbreaks of disease. The assistance involve furnishing the afflicted countries with advice, experts and medical supplies.

> The absence of accurate and comprehensive statistics in many countries can be a serious detriment to the improvement of health at both, the international and national levels. A number of nations have been assisted by the World Health Organization to establish their statistical systems. The Assembly adopted international regulations on health statistics and established certain criteria and principles to be followed everywhere.[13]

The Technical Services Department is involved in the field of medical literature by issuing medical journals and books, and aiding national governments in establishing medical libraries. Technical and scientific publications, printed in several languages

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[13]Stephan Goodspeed, The Nature and Functions of International Organization (New York: Oxford University Press, 1959), P. 403.

are distributed to all member countries.

Finally, "In the field of research, the World Health Organization, while not normally engaged itself in the conduct of projects, collaborates with national institutions and organizations through expert panels and committees. It also subsidizes or supplies personnel to undertake special research of international importance."[14]

The Advisory Services are based on the recognition that a tangible proportion of the population in the world live in areas which are suffering from economic and social backwardness, thus resulting in ill health as a chronic feature of the people. The underlying reasons for the ill health are attributed to the lack of knowledge in tackling and attacking specific diseases, the absence of trained and skilled experts in the field of health who can implement health education into practice and mal-nutrition.

The World Health Organization at the request of national governments provides expert consultants and demonstration teams consisting of highly trained specialists. The advisors and the teams collaborate side by side with the local staff, with the view of

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[14]Berkov, Op. cit., P. 31.

training and guiding them to perform the job and then depart leaving the trained staff to take over the burden of the work.

The Advisory Services of the World Health Organization, runs parallel with the items of the Constitution. "Hundreds of fellowships have been granted by the World Health Organization to enable nurses, doctors, and other health personnel to study abroad. Thousands of annual subscriptions to medical and health periodicals as well as books and teaching aids such as fellowships, slide projectors and automatical charts have been supplied."[15]

The Advisory Services Department in its attempt to promote physical, mental and social well being carries out projects to ameliorate the sanitary conditions, improve the nutrition standards, and attend to maternal health. It also promotes development of preventive mental health work, occupational health and medical rehabilitation by cooperating with other international organizations of different fields of competence. The aim behind the collaboration with other international organizations is to bolster long term economic improvement

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[15] Goodspeed, Op.cit., P. 399.

by national and international organizations especially that in less developed areas, a backward economic and social system might have serious repercussions on the health standards and ethics.

The Regional Arrangements

The distinctive feature of the structural aspects of the Organization call for a detailed consideration of the regional arrangements of the World Health Organization.

The motive to decentralize the activities of the World Health Organization is manifested in Articles 44-54 of the Constitution of the Agency.

The geographical delineation of areas is to be defined by the World Health Assembly with the majority consent of the members situated in each of the delineated regions. The regional organizations as stipulated for in Article 45 of the Constitution form an integral part of the World Health Organization and consist of a regional committee and a regional office.

The regional committees, provided for in Article 47 of the Constitution, are composed of representatives of four types of members, each possessing powers and authority of different degrees of importance, and classified as follows:

> Regional committees shall be composed of representatives of the member states and associate members in the region concerned. Territories or groups of territories within the region which are not responsible for the conduct of their international relations and which are not associate members shall have the right to be represented and to participate in regional committees. The nature and extent of their rights and obligations shall be determined by the Health Assembly in consultation with the member or other authority having responsibility for the international relations of these territories and with member states in the region.[16]

The regional committees are empowered to convene as often as necessary in any place agreed upon by the members and authorized to adopt its own rules of procedure.

The duties and responsibilities of the regional committees are mainly the formulation of the regional policies and the supervision of the activities of the regional offices. In addition, the regional committees

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[16] World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 467.

are empowered to submit proposals to the regional offices concerning the summoning of technical conferences and a scheme for collaboration with the respective bodies having mutual interest in the field of health. The committees are also authorized to render advice to the World Health Organization on international health matters and to recommend to the respective governments of the regions to increase their contributions, especially when the allotments to the region are inadequate. Finally, all functions delegated by the Health Assembly and the Executive Board.

The Constitution further stipulates that the Regional Director is appointed by the Executive Board in agreement with the regional committee. However, the Regional Director in practice is nominated by the regional committee and accepted by the Executive Board.

However, despite the fact that the Regional Director is appointed and accepted by the Executive Board, yet he is administratively responsible to the Director-General and as such has a triple responsibility: To the Regional Committee, to the Executive Board and to the Director-General.

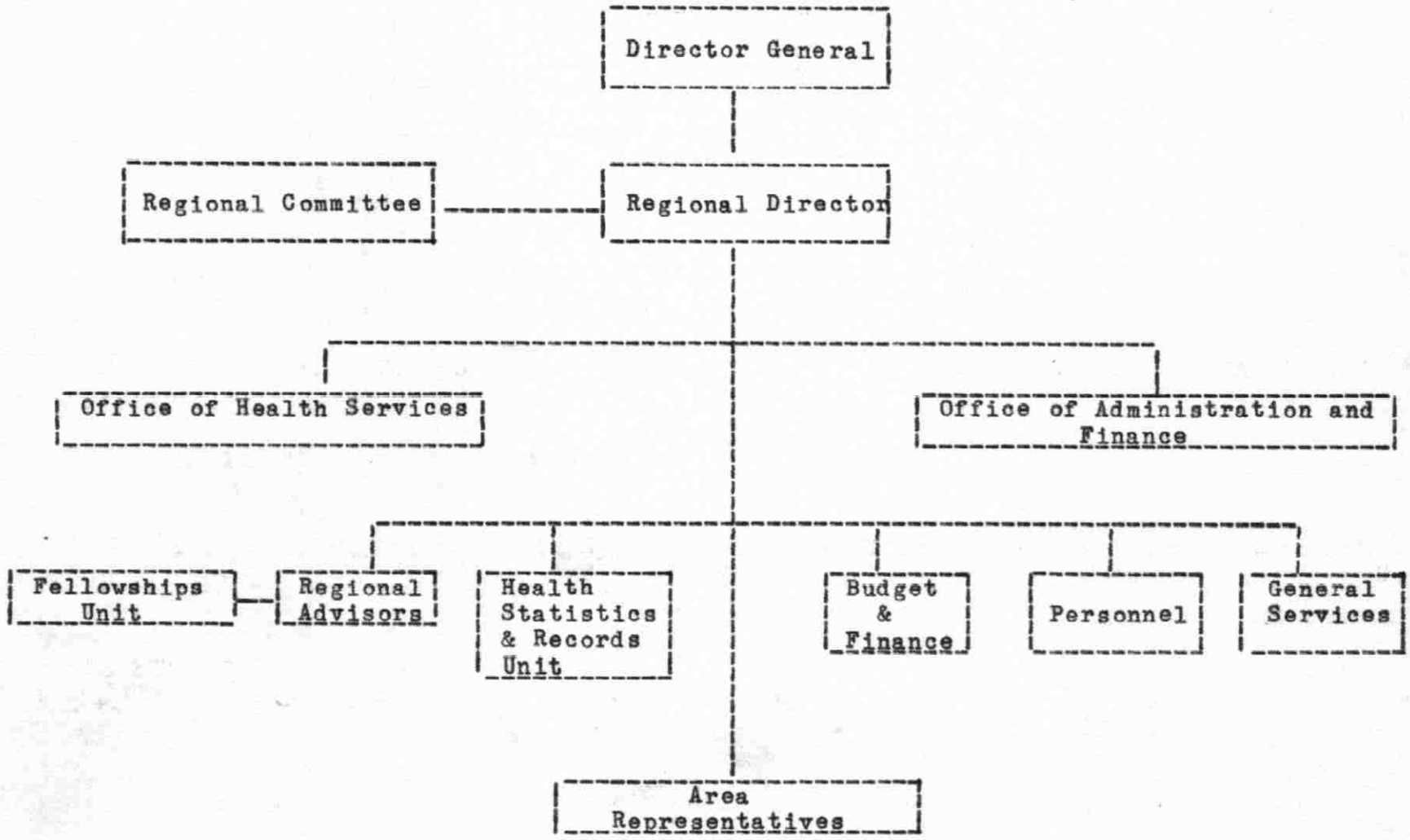
The functions of the Regional Director vary from one region to another, but in general, the Regional Director performs the following functions: He acts as the director and coordinator of all health activities of the region and as a secretary and advisor to the regional committee on the formulation of regional policies. Moreover, He acts as a liaison officer between the regional committees and the Director-General and maintains the necessary contacts with the respective governments and all regional bodies having common interest in the field of health, in an attempt to assimilate and consolidate the activities of the region. Finally, the Regional Director prepares and submits to the Director General the annual report, the budget estimates and all pertinant and requested reports.

The regional office, which is headed by the Director-General is the administrative organ of the regional committee and carries out the decisions of the Health Assembly and the Executive Board. A typical Regional Office appears in Chart IV.

The Six Regional Offices of the World Health Organization are situated as follows:

CHART IV

TYPICAL STRUCTURE OF A REGIONAL OFFICE*



* World Health Organization, The First Ten Years of the World Health Organization (Geneva 1958), P.105.

1. Brazzaville - Africa
2. Washington - The Americas
3. Copenhagen - Europe
4. Alexandria - Eastern Mediterranean
5. New Delhi - Southeast Asia
6. Manila - Western Pacific

The staff of the Regional Offices are appointed by the Director-General in agreement with the Regional Directors. However, the structure and staffing patterns in the Regional Offices differ due to the geographical, social, health facilities and economic status of the region.

The responsibilities of the regional organizations include:

> The preparation of regional programs, the transmission to Headquarters local r eactions to these programs, assistance to governments in planning sound programs, circulation of information from Headquarters and its application to local conditions, appraisal of national health programs, administration of intra-regional fellowships, coordination of the World Health Organization regional activities with those of other agencies, holding of regional conferences and study groups, and assistance to national health administrations in preparing summaries and analysis of their work in accordance with constitutional obligations.[17]

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[17] Berkov, Op.cit., P. 87.

The regional arrangements which are an integral part of the World Health Organization represent a noteworthy innovation in the field of international administration. The action to create regional levels in the organization prevented the rise of a complexed centralized bureaucracy which is remote from the pressing health needs of the community. The regional committees form an important link between the respective governments of the region and the World Health Organization, and permitted for a closer and immediate emphasis on the problems of the region. The importance of the committees lie in their awareness that the needs and suggestions of the regions will receive prompt and thoughtful attention. The great degree of adaptation effected by the Regional Offices to the needs of the region is a remarkable policy of the World Health Organization. The Director-General in 1953 maintained that the policy of the Organization will always refute a policy aiming at blueprinting a standardized structure or procedure at the regional level.

> It was impossible, he said, to tell what form the regional offices would take in the future, at the time he felt that the offices were accomplishing their work with the greatest economy and efficiency by taking into account the wishes of the respective regional committees and the opinions of the Regional Directors. Each of the Regional Directors was fully aware of developments in other regions,

> he assured the Board, and no changes of an organizational nature were made without consulting Headquarters as well as other Regional Directors, and formal authorization was required for major changes.[18]

Relation with Other Organizations

Cooperation and effective collaboration between agencies is indispensable to all international institutions.

Article Two of the Constitution of the World Health Organization stipulates: "In order to achieve its objective, the functions of the Organization shall be to establish and maintain effective collaboration with the United Nations, Specialized Agencies, Governmental health administrations, Professional groups and such other organizations as may be deemed appropriate."[19]

Regular and close liaison between all bodies concerned with improvement of health is considered and appreciated in order to ensure effective tackling of problems encountered by more than one organization entangled in the same field of competence. The aim

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[18] World Health Organization, Report of the Executive Board, 11th Session, No. 46 (Geneva, 1953), P. 4.

[19] World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P.2.

behind cooperative endeavours is mainly avoidance of duplication of work and divergencies of policy.

Formal agreements were concluded by the United Nations through the Economic and Social Council with all the Specialized Agencies, bringing them into closer relationships with the United Nations System. The United Nations Charter recognizes the wide responsibilities conferred upon the specialized agencies mainly to promote higher standards of living, and to suggest and implement solutions and assistance to remedy all international social, economic, health and related problems and obstacles. Coordination of the activities of the specialized agencies is vested in the Economic and Social Council.

By virtue of a special clause, the World Health Organization consents to participate and cooperate with any organ established by the council in order to facilitate the process of coordination of the activities of international institutions.

Article Two of the Agreement between the United Nations and the World Health Organization provides for 'reciprocal representation' between the two organs.

Representatives of the United Nations will be invited to attend the meetings of all the organs of the World Health Organization. Similarly, representatives of the World Health Organization will be invited to attend the meetings of the Economic and Social Council, the General Assembly and its main committees, and the Trusteeship Council.

The proposals of the United Nations in the field of health should be inserted on the agenda of the World Health Organization while also the reciprocal bodies of the United Nations also consider all proposals submitted by the World Health Organization.

The Agreement further states the obligations on the part of the World Health Organization to facilitate the process of coordinating the activities and policies of the specialized agencies by the United Nations. Agreement on the transmission of all pertinant information and exchange of documents between the two organs is stipulated for in the agreement.

Cooperation between the two bodies extend to establish personnel arrangements.

> The two organizations recognize the eventual development of a unified International Civil Service, agree to develop common personnel standards, methods, and arrangements designed to avoid serious discrepancies in the terms of employment, to avoid competition in recruitment of personnel and to facilitate interchange of personnel in order to obtain the maximum benifit from their services.[20]

Other points covered by the Agreement provide for maximum cooperation in the fields of statistical information and administrative and technical services.

Finally, the Agreement stipulates for the establishment of close financial and budgetary relationships between the two bodies to ensure efficiency and economy of their administrative operations.

Formal agreements were concluded between the World Health Organization and some of the specialized agencies which have mutual interest in directing their functions in certain fields where their interests might overlap. The aim behind the agreements lies in their concern to avoid overlappings of functions and duplication of work.

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[20] World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 131.

The specialized agencies which already have concluded agreements with the World Health Organization are : The International Labour Organization, The Food and Agriculture Organization, The United Nations Educational, Scientific, and Cultural Organization, and The International Atomic Energy Agency.

> The agreements make provision for reciprocal representation at meetings, the establishment of joint committees for special purposes, the exchange of information and documents, the coordination of personnel arrangements (especially for the avoidance of competition in recruitment and for facilitating exchange of staff), and the coordination of statistical services with a view to ensuring the maximum technical efficiency and the avoidance of overlapping.[21]

The World Health Organization by virtue of the Agreement with the International Labour Organization, cooperates in joint projects on occupational health. The World Health Organization enters into joint projects with the Food and Agriculture Organization in reforming the lands which are immediately affected by land diseases, in nutritional surveys, and in training courses and seminars on food hygiene. The Agreement with the United Nations Educational, Scientific, and Cultural Organization covers a joint endeavour on issues ofschool health programs,

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[21] Ibid., P. 130.

health training, teaching of social sciences and the medical aspects of research on development of arid lands and utilization of water. Collaboration with the International Atomic Energy Agency entails the use of Atomic Energy in the field of public health and promotion of the welfare and health conditions of the human race.

In addition to the regular arrangements for cocperation provided by the agreements with the aforementioned agencies, the World Health Organization closely associates, by mutual agreements, with other specialized agencies for the accomplishment of particular projects.

Cooperation with the United Nations Childrens Fund is achieved by teams of consultants specialized in treatment of maternal health and diseases of children especially Poliomyelitis. Furthermore, their activities proceed to deal with mental health, rehabilitation and juvenile delinquency.

The World Health Organization collaborates with the United Nations Relief and Works Agency for Palestine refugees by contribution in staff, money, and material to its technical health activities.

At the request of the United Nations, the World Health Organization assisted the United Nations Korean Reconstruction Agency in rehabilitating the civilian population of Korea.

The World Health Organization cooperated with the International Civil Aviation Organization in financing and implementing joint projects pertaining to the sanitation of airports and disinsecting and disinfecting aircrafts. The World Health Organization collaborates with the International Telecommunication Union on matters concerning the transmittal of notifications made under the International Sanitary Regulations and come in touch with the Universal Postal Union regarding the transport of dangerous goods and perishable materials. Relations with the World Meteorological Organization and the Interim Commission of the International Trade Organization are restricted to exchange of letters between the heads of the Secretariats. Excellent working relationships exist between the World Health Organization and the International Monetary Fund, while relationships with the International Bank for Reconstruction and Development is restricted to the assignment of health experts to the various missions organized by the Bank.

Cooperation on the Secretariat levels with the Inter-governmental Maritime Consultative Organization extends to cover exchange of documents and study of common problems.

The Constitution of the World Health Organization authorizes cooperation and consultation with non-governmental organizations, not only those of international character, but also national bodies approved by their concerned governments. Thus the relationship of the World Health Organization with its counterparts extends to deal with organizations and bodies beyond the realm and jurisdiction of the United Nations System. A complete list of non-governmental organizations which are in harmonious relation with the World Health Organization can be referred to in Appendix C.

A considerable amount of cooperation with non-governmental organizations has been made and the results were rewarding. On the other hand, the non-governmental organizations have contributed to the work of the World Health Organization by supplying it with consultants, educational assistanships to enable it carry out its educational programs, and influenced to a certain extent, the attitudes of their respective governments towards the principles and policies of the World Health Organization, thus facilitating the application of the set plans.

The criteria for eligibility of a non-governmental body to come in contact and cooperate with the World Health Organization is governed by the following considerations:

> 1. The organization shall be concerned with matters falling within the competence of the World Health Organization.
>
> 2. The aims and purposes of the organization shall be in conformity with the spirit and principles of the Constitution of the World Health Organization.
>
> 3. The organization shall be recognized standing and shall represent a substantial proportion of the persons organized for the purpose of participating in the particular field of interest in which it operates.
>
> 4. The organization shall have a directing body and authority to speak for its members through its authorized representatives.
>
> 5. The organization shall normally be international in its structure and scope, with members who exercise voting rights in relation to its policies or action.[22]

The procedure for admitting non-governmental organizations into relationship with the World Health Organization is in accordance with standardized and fixed rules of procedure. The motive behind the

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[22] World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 67.

arrangement of the relationship between the World Health Organization and non-governmental organizations lies in preventing the latter from influencing the policies of the World Health Organization and subsequently prejudicially affecting its activities. However, precautions are taken to avoid close relationships with non-governmental organizations which are universal in name but not in spirit.

The rules of procedure for admission of non-governmental organizations into relationship with the World Health Organization follow the following routine pattern: The applicant body is scrutinized by a standing committee on non-governmental organizations set up by the Executive Board of the World Health Organization. The committee after thorough consideration recommends either acceptance, rejection or postponment of the applicant. The final decision regarding admission is a prerogative of the Executive Board. Furthermore, a reconsideration of non-governmental organizations already in relation with the World Health Organization is done every two years in order to determine whether the existing relation should be maintained or terminated.

Non-governmental organizations in official relations with the World Health Organization are entitled to appoint a non-voting representative to the meetings and to address the meetings, upon the initiation of the Chairman, on the item in which it has particular interest. The non-governmental organizations have access to non-confidential documents and can submit a memorandum to the Director-General who retains the right of determining the scope and nature of circulation of the documents and publications of the World Health Organization.

Principles to govern relations between the World Health Organization and regional and national non-governmental organizations as adopted by the Third World Health Assembly culminated in the following classifications:

> 1. Regional or national non-governmental organizations which are affiliated to international non-governmental organizations with which the World Health Organization is in official relations.
>
> 2. Regional or national non-governmental organizations which are affiliated to international non-governmental organizations not in official relations with the World Health Organization.
>
> 3. Regional and national organizations for which there is no international non-governmental organization.[23]

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[23] Ibid., P. 70.

The principles governing the above mentioned Three relationships stipulate respectively that no formal action is required by the regional committee concerning the first relationship, while in the second case arrangements will be on the basis of informal working relations. Finally, the third relationship is subject to consultation between the Regional Director and the Director-General.

PART II

INTERNATIONAL DECENTRALIZED ADMINISTRATION

CHAPTER III

THE ADMINISTRATIVE THEORY OF DECENTRALIZATION IN THE WORLD HEALTH ORGANIZATION

This Chapter will attempt to present the administrative implications of the theory of decentralization and the extent to which it is applied in the World Health Organization. The study will trace the historical background of the concept of decentralization in the Agency and will thereafter assess and evaluate the process and machinery of decentralization in the World Health Organization. Further, the arguments for and against decentralization will be cited along with a detailed presentation of the administrative, social and political problems encountered as a result of the decentralized policy.

The tendency to decentralize was reinforced in large organizations as the concept was sought to bolster local institutions and avoid the jeopardizing and stultifying concentration of power at the center. The variable and numerous programs sponsored by the World Health Organization and the vastness of the scope of operations of the Agency, compelled it to delegate from the center to a large number of sub-units the primary functions and responsibilities in order to ensure the success of its programs.

Decentralization can be classified into two main types: Geographical or territorial; administrative or functional. Thé latter which is applied by the World Health Organization refers to the act of delegation and fulfilment of an administrative task by autonomous bodies which exercise their authority and decision making power through their own independent organs.

The deliberate action of the International Health Conference to decentralize the World Health Organization, prior to its establishment, and the prescription for regional arrangements in the constitution of the Agency as a prerequisite of true decentralization, necessitates the tracing of the historical evolution of the process of decentralization and its subsequent stages of development.

The regionalized aspects of health work preceeded the development of an international cooperation in the field of health to prevent the spread of disease, and it was the institutionalization of these efforts, which confronted the World Health Organization at the beginning. Thus the concept of regionalization in the history of the World Health Organization will be traced.

The issue of regional arrangements and the relationship of the Health Agencies which existed prior to the establishment of the World Health Organization, were the most serious and controversial subjects which confronted the International Health Conference when it convened in New York in 1946. Four outstanding Health Agencies existed prior to the establishment of the World Health Organization, and these were: The Pan American Sanitary Bureau, The Office International d'Hydgene Publique, The League of Nations Health Organization, and the Health Work of the United Nations Relief and Rehabilitation Administration.

The controversy constituted two conflicting point of views. Some delegations insisted on an integrated organization, while others reflected their reluctance to integrate the existing Health Agencies and to amalgamate them into an international Health Agency.

Finally, it was agreed that in due course and through common action based on mutual consent, the regional health organizations be integrated. However, the structure, responsibility and authority of the regional organizations to be established by the World Health Organization, were the second issue on the agenda.

After a long and fruitful discussion, the conference agreed on two major assumptions:

> 1. That both policy making committees and administrative offices were necessary for the effective discharge of the organizations responsibilities at the regional level.
>
> 2. That each regional branch so constituted would be an integral part of the total Organization.[1]

The process of regionalization was enhanced further by the Interim Commission, which proceeded to negotiate amicable agreements with the existing health organizations, mainly the Pan American Sanitary Bureau, for their integration with the World Health Organization. The Interim Commission considered the delineation of areas for regional organizations, but opposition from members arose, on the grounds that such attempts to decentralize the Agency before it is firmly established, and its constitution ratified, is a premature action.

> The Irish delegate said that the World Health Organization is only a new born child and in addressing an assembly of eminent medical men I need not labor the point that one does not expect a child to produce a family until it has reached the age of maturity.[2]

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[1] Robert Berkov, The World Health Organization: A Study in International Decentralized Administration (Geneva: Librairie E. Droz, 1957), P. 57.

[2] Ibid., P.62

Finally, it was agreed to designate five parties for the delineation of broad geographic divisions, and instruct them to bear in mind the delineation of their respective areas and their desirability of establishing regional organizations in those areas.

However, when the proposals were submitted to the Assembly for final consideration and gradual establishment of the proposed regional arrangements, the delegates unanomously adopted the following stipulations:

1. Delineation of areas is a prerogative of the World Health Assembly.
2. The localism of the Regional Office in delineated area depends on the consent of the majority of the members in the area.
3. The Alexandria Bureau in the Eastern Mediterranean area would be integrated with the World Health Organization.
4. A special administrative set-up would be established for Europe to meet the pressing demands of the European people for rehabilitation in war devastated countries.

The Assembly, subsequently, delineated six geographic areas, for the eventual establishment of regional organizations. The Geographic areas were as follows:

1. Eastern Mediterranean Region
2. Western Pacific Region
3. South East Asia Region
4. Europe Region
5. Africa Region
6. The Americas Region.

Thus the way was paved for the establishment of regional arrangements. Commenting on this decision an Assistant Director-General of the World Health Organization declared "It was perhaps a little premature to establish the regional Organizations before the WHO had had time to get its central establishment working smoothly, but it certainly stimulated regional interest from the beginning and ensured that centralization did not become too firmly established."[3]

The establishment of regional arrangements and the functioning of regional set-ups undoubtedly contributed

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[3] Neville M. Goodman, International Health Organizations and their work (London: J. & A. Churchill, Ltd., 1952), PP. 253 - 254.

to the implementation of decentralized policy. The regional machinery acquired from Headquarters important functions of formulating their programs in respect with their ecology and basic needs, and budget thereof accordingly. The delegation of such functions was deliberately initiated by the Headquarters Officials. This initiative of delegating functions to regions was an obvious indication of the intention to decentralize the Agency, which was ultimately facilitated by the regionalized pattern existing. However, although regional organizations could have been established with authority and decision making power concentrated at the Headquarters, yet the delegation of the primary functions of formulating the programs and recommending the budget estimates, is a symptom of decentralization and not regionalization.

The World Health Organization, emphasized in its early days on six fields in international health work, known as the 'Big Six Priorities'. However, three years after the formal establishment of the Agency, and the incorporation of the initial steps for regionalization, the need for an extensive revolutionary change in the environment in which the World Health Organization was operating was deemed essential.

The annual report of the Director-General to the World Health Assembly reported "As a result of experience and the nature of requests from governments, the general policy guiding WHO operations had inevitably to move away from what had come to be known as the 'priorities' ... to a system which can be said to embrace any form of assistance needed by countries for the general promotion and care of health."[4]

The greater authority and responsibility vested in the regional organizations and the important contacts made through and with the regional offices by the host countries in the regions, necessitated the change in the policies of the Agency by adapting the programs and activities to the different local conditions and needs. However, the Constitution of the World Health Organization sets forth two important functions which prescribe the wide scope and extent of operations embraced by the Agency. These two functions stipulate:

> 1. To act as the directing and coordinating authority on international health work.
>
> 2. To assist governments, upon request, in strengthening health services.[5]

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[4]Official Records of the World Health Organization, The Work of WHO: Annual Report of the Director-General to the World Health Assembly and the United Nations, No. 30 (Geneva, 1950), P. 1.

[5]World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 460.

The feature of regionalization which characterized the Agency did not transcend geographical decentralization, and the scope of operation of the Agency simply embraced the delineated regions which were controlled and directed from the Headquarters. However, the essential change in the environment of the Agency and the shift in emphasis to a greater adaptation to local conditions and needs of the people in the regions obliged the agency to implement the policy of functional decentralization along with the geographical decentralization.

The underlying principles which outlined the philosophy of decentralization implemented by the World Health Organization were expressed by the Director-General as follows:

> Increased decentralization has brought the Organization into closer touch with the most immediate needs of the member countries and has enabled WHO to begin to assist each country in taking the next appropriate step toward developing the public Health services within the limits of its economic, social and cultural circumstances.[6]

The World Health Organization was initially established on a highly regionalized basis, and its programs were

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[6] Official Records of the World Health Organization, The Work of WHO: Annual Report of the Director-General to the World Health Assembly and the United Nations, No.30 (Geneva, 1950), P. 2.

restricted to certain health activities known as the 'Priorities'. Later, a gradual change in the system and the programs began to crystalize. A progressive regionalized pattern which is a feature of decentralization was implemented and the programs started to be adapted to the outcrying basic needs of the various countries at the regional levels. The change in the orientation of the general policy of the Organization, was a shift from confined regionalization to the realm of decentralization.

> By 1954, the Executive Board forthrightly stated that the program had moved away from the priorities towards assistance embracing a broader range of activities for the general promotion of health. The program can be said now to give emphasis to strengthening national and local health services.[7]

It is apparent, therefore, that the decisive change which have occurred in the general policy of the Agency is directly related and attached to the policy of decentralization which the World Health Organization has embarked upon and exerted demonstrable results.

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[7] Official Records of the World Health Organization, The report of the Executive Board: Review of Organization Structure and Administrative Efficiency, IV, 7th Session, No.33 (Geneva, 1951), P. 2.

A conspicuous feature worth noting is the fact that while the World Health Organization was progressively regionalized, it was simultaneously decentralized, as the most important functions of planning, programing and execution of the projects resolved by the Health Assembly were delegated to the regional levels.

> It should be emphasized, that whereas in the World Health Organization, the objectives of the process of decentralization are sought by means of regionalization, the two processes are synonymous. Because decentralization is frequently carried out, in national and provincial administration, on a geographical basis, there is a temptation to confuse the process of geographic dispersion of an organization with decentralization.[8]

With the elapse of time, the regional organizations started submitting to the central set up, plans and programs based on the wide decentralized features of the distant regions. Consequently, serious repercussions on the policy of the World Health Organization were manifested which diverted its policy away from the 'priorities' to a broader range of activities aiming at the general promotion of health. On the other hand, the reflected change in the programming which the decentralization has introduced at the regional levels modified many of the weaknesses faced by the regional offices.

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[8] Robert Berkov, The Work of the World Health Organization: A study in International Decentralized Administration (Geneva: Librairie E. Droz, 1957), P. 17.

> Two trends made a change inevitable. One was the change of emphasis previously noted away from the "big six" priority program to assistance in strengthening national health administrations. The latter approach called for generalists in public health administration rather than specialists, persons who were highly competent in surveying general health needs, in organizing and reorganizing departments, and in coordinating programs, rather than those skilled in combatting one of the diseases mentioned, proved to be the principal need of the Regional Offices.[9]

The emphasis on generalist approach developed a pattern assigning regional advisors to a country or group of countries within a region, known as area representatives, whose principal function is coordination and liaison. The administrative, personnel and financial functions were maintained by the regional offices.

Other than the structural change at the regional levels, an evolutionary change in the regional programs was witnessed, as an impact of the decentralized policy implemented by the Agency. The program formulations and budget estimates of the regional offices in the beginning, represented a collection of individual requests submitted by the respective countries within the region, and subsequently the main concern of the regional committees

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[9] Ibid., P. 72.

when reviewing and scrutinizing the proposals of the regional offices, resolved around maintaining the appropriated budgetary ceiling rather than with the merits and adequacy of the proposals in relation to a balanced public health program for the region. Later, a new and proper perspective was contemplated and effected when scrutinizing the proposals. Devotion and attention was attributed to relate the request of a country to the objectives of the program for the general good of the region, and due consideration of the potentiality and ability of the constituent countries to absorb and resume a particular program after the termination of the Agency's assistance. The planning of seminars and conferences to tackle unique problems of a region, which are remote and unrelated to the health authorities in the counterpart regions, was an important function, increasingly seized and developed by the regional offices. Inter-country programs on mutual health programs, jointly administered and processed by several adjacent countries within a region, were enthusiastically stimulated.

The genuine progress attained in the regional programs, and the close collaboration among the regions was attributed to the development stimulated at the regional levels and substantiated by the Executive Board.

The increasing success and recognition which the World Health Organization encountered, widened its scope of operations and the physical proximity over which it functions. The area representatives, who are responsible for one or more country, were obliged to maintain Headquarters away from the regional offices. This arrangement in the beginning did not represent a decentralized action as there were no delegation of decision making powers or exercise of administrative responsibility but simply constituted geographical subdivision. However, a significant amount of regional decentralization was applied by establishment of zone offices. This structural arrangement of zone offices meant that direct responsibility for planning and execution of the regional programs was granted to zone representatives. The role of the regional office in the area would be to coordinate and appraise the operations of the zone offices and to secure conformity with the general and financial policies of the Agency. In addition, it will tender advice and extend cooperation when needed. As the plan for further regional decentralization materialized, more important functions of the regional offices were delegated to the zone offices. Increased participation and responsibility for the preparation of the budget estimates, incurring of

obligations, and appointment of local personnel was transferred to the zone representatives. Participation was not restricted to the zone office staff only, but to field project staff as well, as they are closer and more aware of the real and pressing needs of the community. However, the designated area representatives do not constitute further decentralization in all the regions of the Agency, but are merely a mean to ensure closer coordination and contact with the governments of the region, due to the many social, economic and geographical limitations imposed by the regions. Thus the degree and extent of decentralization is not consistently uniform in all the regions of the Agency. Decentralization in the distant under developed region of Western Pacific as compared with the region of the Americas is substantially insignificant. Many factors such as the social background, customs and norms of the people, relegion, backward economic conditions, ill health due to poverty and mal-nutrition, the geographical dispersion in the area which retards communication and requires heavy transport expenses, affect the variation in the degree of decentralization enjoyed by the regions of the World Health Organization.

However, the constant amelioration of the economic and social conditions of underdeveloped areas, the

greater influence of westernization and the tremendous progress in the means of communication and transport with and within the regions, manifested a wide variation in the regions whose degree of decentralization is limited. This symptom appeared early in 1957 and further decentralization was being attained by gradual establishment of area representatives and zone offices. At present, although, the Six Regional Organizations are decentralized, yet the degree and extent of decentralization as measured by the number of area representatives and zone offices in the regions, confirms the variation in the degree of decentralization in the regions of the World Health Organization.

The pattern and decision for establishment of area representatives in an area and affecting further decentralization is as follows:

> The question of how the work of the Organization should be carried out in the region is considered in the first place by the Regional Director and the Regional Committee, who submit the program to the Director-General, who in turn submits his recommendations to the Executive Board and the World Health Assembly. Therefore, although it is the function of the Regional Committee to make recommendations on regional matters, the Director-General, the Executive Board and the Health Assembly all shared responsibility for decisions on those recommendations.[10]

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[10] Official Records of the World Health Organization, Report of the Executive Board, II, 15th Session, No.61 (Geneva, 1955), P. 43.

> The pattern is highly indicative of the state of decentralization in the WHO, since the initial action was recognized as the responsibility of the regional committees, on the basis of an original recommendation by the regional director. Clearly, then, despite the existance of provision for review by the Director-General, the Board and the Assembly, and the obvious possibilities of a veto at any stage in the upward movement of the proposal, the WHO's 'Locus of decision' in such matters is definitely at the original level - an eloquent confirmation of the genuine decentralization of the Organization's administrative functions.[11]

Decentralization in the World Health Organization was achieved initially by regionalization, and subsequently by delegation of authority and responsibility from the Headquarters to the regional set-up.

The constitution of the World Health Organization in Articles 44 - 45 provide for the structural and functional arrangements of the regional set-ups. Each of the regional organizations, consists of a regional committee and a regional office. The regional office is composed of a regional director and a subordinate staff. However, the detailed analysis of the regional mechanism as to its membership authority and functions, and the administrative implications involved, presented in Chapter II of this study under the structural aspects of the Agency, confirms and

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[11] Berkov, Op.cit., P. 76.

indicates the extent and impacts of decentralization on the Agency. The basic functions and authority delegated by the Headquarters to the mechanism of the regional organizations, is a measure of decentralizing the regionalization of the World Health Organization. Although a clear cut line of demarcation between the responsibilities of the Headquarters and the regional organizations cannot be delineated, yet, the role and authority which the regional organizations are endowed with perpetuates the concept of decentralization in the World Health Organization. The Agency, willingly has encouraged regional organizations and their subordinate bodies to adapt their operations to the conditions and needs of the respective areas in the region and to avoid any blueprinting of standardized structure or procedure. The encouragement of such a policy of adaptation, is an indication that the World Health Organization advocates the policy of decentralizing the rigid regionalized patterns.

In outlining this philosophy to the Executive Board, the Director-General maintained that:

> Headquarters had never attempted to force standardization on the Regional Offices. It was responsible, he said, to tell what form the Regional Offices would take in the future, at the time he felt that the offices were accomplishing their work with

> the greatest economy and efficiency by taking into account the wishes of the respective Regional Committees and the opinions of the Regional Directors. Each of the Regional Directors was fully aware of developments in other regions, he assured the Board, and no changes of an organizational nature were made without consulting Headquarters as well as other Regional Directors, and formal authorization was required for major changes. [12]

The role of Headquarters in implementing the policy of decentralization was of gradual reliquishment of functions and constant changes and adjustment in an attempt to obliterate the rigid feature of regionalization predominating over the Agency and develop the regional patterns into a progressive true decentralized units. The Headquarters, which was still involved in direct regional operations, repeatedly endeavoured to get rid of any involvement in operations and to concentrate on its primary functions of providing leadership, tendering technical advice, coordinate regional operations to ensure uniformity, and to perform services of a centralized universal nature. The changing responsibility of Headquarters from direction of missions and involvement in the operation, to the role of a leader, advisor and coordinator was one of the stimulants which advanced the process of decentralization in the World Health Organization.

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[12] Official Records of the World Health Organization, Report of the Executive Board, 11th Session, No.46 (Geneva, 1953), P. 4.

However, a complete shift of responsibility for regional affairs to the regional offices could not be achieved by Headquarters, due to many reasons mainly structural hindrances and political controversies. An illustration, is the political dispute between the Arab States and Israel, as the Arabs consistantly refuse to administer health programs for and in Israel from the Regional Office of the Mediterranean at Alexandria and abstained from attending the meetings of the Regional Committee with Israel. Thus all health matters concerning Israel, should be communicated by the Regional Director, who is stationed in Alexandria, to the Headquarters for action.

An illustration of a responsibility imposed upon Headquarters of the Agency, even when the regional offices are able and willing to execute such a responsibility, is due to the structural differences existing between the Agency and other specialized agencies. The World Health Organization in collaborating with other specialized agencies such as the International Labor Organization or the Food and Agricultural Organization, cannot execute the joint projects at the regional levels, because the other agencies are not regionally organized, or organized on a different regional basis, or their regional representatives do not enjoy the authority and responsibility delegated to the regional staff of the World Health Organization.

> The Headquarters of the World Health Organization has had to cope not only with a changing concept of its responsibilities, but with the burden of double responsibilities as well. While cooperation at the regional levels is important, yet the major emphasis should be placed on coordination among the various organizations at Headquarters.[13]

Before proceeding further to disclose the current problems and hindrances arising from the decentralized policy implemented by the World Health Organization, it is judicious to present the arguements for and against the administrative theory of decentralization, in an attempt to reveal the merits and defects of a decentralized organization such as the World Health Organization.

A general arguement in favor of decentralized organizations, clusters around the basic idea that decentralization enhances efficiency, which ultimately contributes towards the effective attainment of the set goals of the organization. However, the same arguement is advanced and substantiated by advocates of centralization, on the grounds that a consolidation of the primary functions at the center, eliminates duplication and reduces the cost of the operation.

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13 Robert Berkov, The World Health Organization: A Study in International Decentralized Administration (Geneva: Librairie E. Droz, 1957), PP. 102 - 103.

> Conversely, if decentralization makes it easier to gain such consent, then the arguement for decentralization may be valid even if the process appears to involve greater financial outlay or the acceptance of a certain amount of duplication of activity between Headquarters and the various decentralized units.
>
> Whereas the advantages of centralization have been strongly urged on the basis of efficiency, students of administration have long agreed that there is danger in centralized government of failure to differentiate between communities whose circumstances are widely varient.[14]

Centralization, was dominantly the general rule of international organizations, however, currently the World Health Organization can be nominated as one of the decentralized international agencies. The policy of centralization, particularly at the international level, has inevitable defficiencies and serious pitfalls. The aloofness of the Headquarters and its staff, their remoteness from the place of operation, and the over-centralization of the organization will generate discrepancies such as administrative red tape, deadlocks, duplication, a spirit of suspicion among the staff at Headquarters, psychological reactions at the regional levels, and lack of adaptation in the programs to the regional needs.

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[14] Ibid., P. 19.

The consolidation of the practice of regionalization, which can be entirely developed without a corresponding degree of decentralization, with that of true decentralization, by actually delegating authority to the geographic area offices, a number of benefits and advantages will accrue as a consequence of such a physical departmentalization.

However, many of the theoretical advantages of decentralization, such as reduction of red tape and duplication of work, and the delegation of authority, decision making power, responsibility and discretion may pose corresponding disadvantages and disagreement by the advocates of a centalized system who maintain that the process of delegation of decision making powers will create subsidiary problems. Thus, in order to assess and evaluate reliably the advantages accruing to the World Health Organization from its decentralized policy, an attempt will be made to pinpoint the practical benefits of decentralization, and to disregard all the theoretical and general arguements in favour of the decentralized system practised by the Agency.

The first merit gained from the decentralized policy is attributed to the greater degree of adaptation of the programs of

the World Health Organization to the pressing and variable needs of the areas.

A second advantage derived from decentralization in the Agency is attributed to the fact that the respective governments in the area will feel less remote from the source of the International Health Program administered by the Agency at the Central Level and positively attached and involved in their direct interest which is stimulated at the regional levels by the decentralized pattern of the Agency. The success achieved and the human contacts availed by the regional offices intensified the beliefs of local governments in the decentralized system of the Agency and redressed the grievances which they had about the establishment.

Another supporting arguement in favour of the decentralized system implemented by the World Health Organization is manifested in the greater participation, number of members, financial contributions and in the work and programs of the Agency. Thus the members and associate members of the Agency in 1956 stood at 88 against 115 participants in 1962. Furthermore, the effective working budget for 1956 totalled $10,203,084 as compared to $23,607,180 in 1962.

> Another achievement which must be credited to the World Health Organization is that the decentralization has been achieved without sacrifice of essential control of policy from Headquarters. If it were true that the application of policy were left exclusively to the regional organizations, there would be genuine ground for apprehension. Adaptation to local conditions, in that event, might easily prove a shield for a modification of policy, or even an opposition to accepted policy. Such application is, however, not left to regional discretion in the World Health Organization.[15]

The regional program formulations and budget estimates, which are prepared by the regional office, screened by the regional director and scrutinized by the regional committee, are reviewed by the Director-General, and defended before the Executive Board and Health Assembly, prior to the final approval for the programs and budget estimates.

The staffing pattern at Headquarters, who is endowed with critical talents and faculties, analytical abilities, and technical competence, in order to perceive the total programs of the World Health Organization, from a universal point of view, aids in maintaining good control over the regional levels despite the progressiveness in the decentralized system implemented by the Agency.

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[15] Ibid., P. 155.

Thus any deviation from the prescribed policy, will be pinpointed and amended by an appropriate action from the Headquarters in due time. Even, if the deviations confront the Headquarters as an accomplished fact, careful planning and sound prompt communication by Headquarters to the respective region, will guarantee immediate amelioration of the situation and the hazardous consequences of the error committed. The representatives appointed by the Director-General in the regional offices, for the administrative and financial phases, are additional means of control imposed by Headquarters. The Director-General can veto the recommendations of the regional offices, controls the efficiency of the Division of Administrative Management and Personnel and review all the financial transactions by his internal auditors in the field.

Credit to the decentralized system of the Agency rises from the continued operation by the Headquarters of all the technical services, other services due to political or structural reasons, the financial controls, and all the counter checking prerogatives which serve as an asset in preventing any fragmentation or departmentalization of the work of the Agency or even its conversion into a loose federation of regional health organizations.

Furthermore, the nature of the operations conducted by the Agency, mainly the field of health, cannot be successfully undertaken without the consolidation and dissemination of the assembled data on health matters in the area where the real health problems exist. It realized that the initiation of a resolution directly at the operating level will result in notable efficiency and economy in time, human and financial elements.

The decentralized pattern in the Agency provided greater ease of coordinating the health projects in the regions. Projects executed in the regions are definitely better coordinated at the regional levels than by the distant Headquarters. Moreover, assuringly, decentralization has promoted better cooperative relations and stronger ties with the subsidiary government units and health institutes in the countries of the various regions.

The disadvantages or liabilities arising out of the decentralized pattern applied by the World Health Organization as compared to the aforementioned advantages or assets accruing to the Agency, will be likewise considered. However, the financial and personnel disadvantages of decentralization will be presented under the pertinent phases of this study. This problemic

presentation will embrace the administrative problems, which comprise the constitutional, organizational and management aspects, the geographical or communication problems encountered by the Agency in running its operations effectively.

The most outstanding problem encountered by the World Health Organization during its execution of the work, both at the central and regional levels, is the success in maintaining a uniform policy despite the structural and health differences in the regions and the geographical disparity between the source of the policy and the place of its implementation. The greater the amount and extent of delegation of the policy, the wider is the margin and probability of distortion in the picture. Consistency and uniformity of a policy is disrupted by further transmission and stages before the prescribed policy reaches the destination.

The failure to maintain uniformity in the broad lines of the policy in general and the financial policy in particular, is due to the unavailability of formal and objective set of criteria for the comparison of one program to another and assessment of the importance of a program to the total objective and policy of the Agency.

The only practical course in allocation of resources and programs among the regions, is in estimating the actual needs of the countries and their capacity in absorbing the programs.

> No objective criteria exist on the basis of which the degree of technical development of an individual country, in relation to another, can be assessed. Hence it was asserted that no lists of factors could be devised which could be uniformly applied to measure, for all projects, all countries and all regions, the allocation of available resources, the guiding principles to which reference was of a qualitative rather than a quantitative nature. They had proven to be reasonably effective in practice, and then application should become more efficient and acceptable as knowledge and experience is gained in their use.[16]

A correlary to the above disadvantage arises out of the decentralized policy of the Agency to the remote regions and the further decentralization within the region itself by the regional headquarters to the regional and sone Offices. The wide area covered by the Agency, the physical dispersion between the source and the operating levels, the variation in the needs of the many areas and the variety of the projects enforced, all these factors raise the danger of narrowness and short sightedness of

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[16] Official Records of the World Health Organization, Report of the Executive Board, II, 13th Session, No.53 (Geneva, 1954), P. 1.

the management in controlling and coordinating the program in the distant geographical sub-divisions.

A second disadvantage of decentralization is attributed to the difficulty in rendering the needed technical services to all the respective regions and sub-divisions as such services are solely directed and controlled from the Headquarters and are not delegated to the regional levels. Thus the multiplicity and complexity of the technical services and the physical disparity between the central and regional units, deter and hinder the effective rendering of such services.

The reluctance to delegate the primary functions to regional levels, forms another outstanding liaibility. The difficulty in maintaining uniformity and precision in the policy, in keeping contacts with the operations and staff at the regional levels due to physical remoteness, in avoiding an increase in the consequences of error and their seriousness, and in loosing the necessary control over the regional levels, stimulate and intensify the hesitancy to delegate. Furthermore, the tendency to influence favourably the perception of the central unit about the needs and conditions of an area. The influence, if not the control of the local

pressure groups and national governmental bodies, might be effectively strengthened by more delegation of authority and responsibility to the regional units and sub-units. The influence of national policies and groups, cultural patterns and international politics brings up many problems. The attempt to harmonize between the programs of the Agency and the national policies in a region is a difficult and complicated function.

The involvement of the Agency in too much adaptation and adjustments to the peculiarities of the regions, constitutes a disadvantage of the decentralized policy of the Agency, as a divergence from the general broad lines of the policy to a specific and narrow policy will unconsciously occur to conform with the peculiarity of a regional subdivision. Such a shift of emphasis is a consequence of the stress on regionalization more than on true decentralization. Delegates to the Agency in this connection have declared and asserted that "the role of the Assembly is to rise above regional concepts and attitudes and to integrate regional problems into that whole which we call World Health."

> A member of the Executive Board referring to the excessive and distorted emphasis on the need for regionalization, warned that if unchecked would lead in rapid

> geomatric progression, to a separation from the central organization which is being weakened in important functions.[17]

A liaibility of decentralization is attached to the increasing costs involved in implementing a decentralized policy in an Organization. However, this statement as applied to the decentralized policy of the World Health Organization has its pros and cons. One point of view as expressed by the advocates of decentral ization in the World Health Organization maintains that a decentralized organization is an extraordinarily expensive form of organization but is extremely efficient and effective. The increased expenditures offset the detrimental financial effects of decentralization by the enhanced effectiveness in the programs of the organization.

The other point of view states that irrespective of the fact whether the benefits accruing to the Agency from decentralization are worth the cost incurred, decentralization in the World Health Organization is a more costly system.

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[17] Official Records of theWorld Health Organization, Minutes of the 7th WHA, No. 55 (Geneva, 1954), P. 90.

In fact the argument whether decentralization in the World Health Organization is more costly than a centralized administration, is a question of value more than financial statistics.

> There is a ubiquitious demand for economy, which becomes increasingly strong in periods of economic stress and depression. Falsely used, the term means only a diminution of public expenditure properly deferred, it is simply the best or least wasteful utilization of the available means, the objects of expenditure being given.[18]

The opinion against the implementation of a decentralized policy in the World Health Organization was based on the premise that decentralization is not justified unless the benefits accruing to the Agency are equal to the pecuniary value incurred. This contention in fact is debatable, yet it is undeniable that the decentralized policy affected by the World Health Organization has increased the administrative and operational expenses to cover additional staffing, transport and budgetary considerations. The decentralization of the regional organizations into further geographical subdivisions involve additional statutory and staffing expenses.

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[18] Herman Finer, "Administrative Organization", Encyclopedia of the Social Sciences, XI, P. 481.

Negative features of decentralization in the World Health Organization are attributed to the over-weighing of the regional considerations when assessing the broad line policy of the Agency, to the increasing emphasis on long range programs, to the difficulty in use of specialists and the exchange of technical information.

Another liaibility of decentralization is that of difficulty in coordinating the work of the Agency which is distributed over different and remote locations in the globe. Moreover, difficulties of coordination are not restricted to the internal structure, but also extends to the external set ups. Close relationship exist between the World Health Organization and the United Nations System in general and the Specialized Agencies, Inter-governmental and non-governmental agencies. The process of coordinating the programs of the World Health Organization, internally and externally, is a vital prerequisite to attain efficiency and economy, and to reduce red tape, duplication and distortions.

Physical disparity creates many problems and hindrances which retard and disrupt the effective flow of work. In addition to failure in maintaining a uniform policy, difficulty of coordination and control,

and deficiency of standardization in procedures, outstanding and serious problems of equal importance are communication barriers and transport cost.

The improvement of relations between the Headquarters and the regions is essentially a question of improved communication. The exchange of knowledge and experience is fundemental to the success of the Organization in seeking its objectives, particularly, when its admihistrative system is largely decentralized.

Formal reports and correspondence can hardly substitute the understanding which arises as a result of verbal and personal staff discussions. When such discussions involve communications with the respective regional offices which are situated in the remote parts of the world, and when the transport cost constantly exert financial limitations, the promotion of such communication becomes a major problem of the Organization.

Furthermore, the difficulty to communicate in some regions is attributed to the lack of adequate communication media within the region itself.

The outstanding constitutional and organizational problems in the World Health Organization, which so far are not amended or rectified are the following:

> 1. The status of the Regional Directors who are not appointed by the Director-General but are administratively responsible to him.
>
> 2. The dual allegiance of the Regional Directors to the Regional Committee on the one hand and to the Director-General on the other hand.
>
> 3. The rights of Associate Members in the Regional Committees whether such rights should be changed and if in the affirmative whether they should be changed on a world wide basis by the Assembly or on ad hoc basis by the various Regional Committees themselves.[19]

The lack of sound and clear cut lines of responsibility raise many serious organizational and management problems in the World Health Organization. The fact that the Headquarters has to assume obligatory double responsibility, at the central and regional levels, due to its decentralized structural and operational system, create many procedural and administative problem.

The following are outstanding problems of responsibility at the central level:

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[19] Berkov, Op.cit., P. 160.

1. The responsibility of Headquarters for technical advice to be conveyed clearly to all its offices and units.
2. The organization of a stimulation and support movement by Headquarters to all the units at the regional levels.
3. The need to coordinate its programs with the programs of the regions and other international organizations.
4. The technical role of establishment of international procedures and standards to be adopted and followed at the central and regional level. Illustration is the standardization of drugs, and personnel and financial policies.
5. The broad responsibility of Headquarters towards the Regional Directors, Committees, and Offices so as to keep them on the alert regarding their programs and activities.
6. The administration and interpretation of the International Sanitary Regulations.
7. The control and supervision of all internal audit and staff practices and procedures.
8. The establishment of up-to-date statistical relationships and the conduct of research for the promotion of better health standards.

9. Compilation of data and issuance of publications and medical literature on the field of health.

In addition to the aforementioned administrative problems of decentralization, social and political problems also arise which should be considered due to their notable effect on the role and functions of the World Health Organization.

The wide scope of operation covered by the World Health Organization includes many nations of different social backgrounds and political inclinations. The differences in the social and political systems of the Nations who are members in the World Health Organization disintegrates the uniformity in the policy of the Agency and raises peculiar and unique problems in the social and political spheres which effect the cooperative endeavour of the Agency to promote the health standards and economic and social conditions of the human race.

> The first task of the World Health Organization is to create a world climate of opinion that will generate a recognition of the need for governmental action in such fields as nutrition, mental health or health education of the public. As in many other social advances,

> the climate may be modified by voluntary associations rather than official bodies, with which the World Health Organization will want to collaborate.[20]

The resolutions of the World Health Organization have no operative forces and cannot be enforced by sanctions but depend on the understanding and willingness of the country in which the project is to be implemented. Many of the local customs, taboos and norms hinder the progress of health. To illustrate the insurmountable strength of tradition and their detrimental effects on promoting the standards and ethics of health, reference is made to the effort of the World Health Organization to assume the application of professional medical standards in the field of health which failed drastically especially in under-developed areas. A strong resistance to change and progress was manifested by the natives for cooperation with the officials of the World Health Organization due to their low standards of living and education and the influence and domination of their cultural patterns, attitudes and customs over their mentality and perception.

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[20] Charles A. Ascher, "Current problems in WHO's program," International Organization, VI (February, 1952), P. 29.

The prevailing and dominance of national loyalties and values of group solidarity, will create strong resistance to change and reluctance to accept innovation.

> In a small township of Western Nigeria, a field mission from the World Health Organization dug several deep wells, lined them with concrete, and installed cables to raise and lower water buckets. But the natives refused to use the wells. It was discovered that tribal customs are very specific about who has to do certain kinds of work. In this instance it was the man's job to dig the wells and the woman's to carry the water. Raising the water buckets to the well-head, however, was something in between, and the women flatly refused to do what they considered to be a men's job. As for the men, they stubbornly and bluntly refused to turn the handle of the winch to raise the water buckets. The result was that the women were sent a distance of two miles to bring water from a polluted, muddy stream. Even when the stream dried up, the well was not used. Instead, the women were sent to another stream, this time four miles away, where they had to fight the residents of another village who believed the stream to be their property. Patience, understanding and considerable attention to sociological conditions before a project is begun are requisite elements in the work devoted to improvement of World's Health.[21]

The progress in the fields of Medicine and health require simultaneous developments in the social, economic and political fields if it is to produce fruitful results.

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[21]Stephan S. Goodspeed, The Nature and Function of International Organization (New York: Oxford University Press, 1959), PP. 416 - 417.

The successful attempt to control "Trypanomiasis", which had serious social repercussion, as it reduced the mortality rate from sleeping sickness by either detecting the virus carriers or protected its spread by reducing the virus reservoir. However, despite this great medical success, the people's mode of living and culture, and their backward economic environment, still exposes them to all the risks of the disease and susceptability for its spread. Although the preventive medical means of vaccination and individual treatments exist, yet the broad curative methods are not finding fertile grounds.

> To the attempts to destroy the causal agents must be added increased efforts to achieve hygiene education, health education, transformation of living conditions and a triumph over nature by economic and social progress. Wells and latrines in villages, better clothing, better housing, and better feeding are important factors for the improvement of health which do not come within the competence and resources of medicine alone. These facts are fully recognized by WHO and other specialized Agencies. Their several joint projects and the expanded Technical Assistance program of the United Nations represent a beginning toward an improvement of general health condition. Much more is needed, however, and the burden of responsibility rests primarily with individual governments. What WHO, the other specialized Agencies, and the United Nations will be able to do will be determined, not by international councels, but by governments and peoples the world over.[22]

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[22] Ibid., PP. 416 - 417.

The constitutional stipulation stating that the World Health Organization is to assist governments upon request in strengthening the health services and furnishing the technical assistance needed, gained greater significance. However, the reasons for the ineffectiveness of the international teams assigned to strengthen the local health services culminates in the lack of cooperation from the national health units and absence of the qualified staff, potentialities, and expert knowledge in carrying out the mission after departure of the team. Moreover, the numerous demands lodged by the inexperienced newly independent nations whose resources are inadequate, hamper the effectiveness and significance of the constitutional stipulation due to the limited financial and non-financial potentialities of the World Health Organization to cope with the local demands and conditions.

Another social problem faced is that of adaptation of the programs and field operations of the World Health Organization to the different regional arrangements to meet the peculiar social needs and conditions of the region and ensure success of the programs. The World Health Organization is obliged to consider the needs of each individual country to enable it take the next appropriate step of designing the field operations and projects for that country in accordance with the different

regional arrangements and sociological factors within the regions. So, long range plans and local projects should commensurate with the needs and mentality of the region and its geographical sub-divisions.

> Health Administration and medical scientists in all the organs of the World Health Organization - Assembly Board and Secretariat - complain that if only politicians would get out of their way, the World Health Organization could really put on a program of World Health.[23]

The close correlation and association of health with politics and the difficulties encountered in divorcing political issues from health matters constitute a serious impedement to the work of the World Health Organization. The Agency operates on a world wide global basis, covering many nations and countries whose political inclinations and ideology are inconsistent. The decentralized regional policy and the further decentralization within the regions, raises many political disputes and controversies which have inevitable repercussions on the needed spirit of cooperation and understanding of the weaker states.

Nations of the world have earnestly endeavoured to unite in combatting epidemics. They have collaborated

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[23] Charles A. Ascher, "Current Problems in WHO's Program," International Organization, VI (February, 1952), P. 40.

because they realized that disease does not respect the physical boundaries, but transcends it spreading menace and calamities. Historical experience have taught them that their self interests are best served by a world wide collective action to eradicate communicable diseases and promote positive health conditions. However, despite their realization of this fact, yet many of the national political issues could not be ignored and considered as secondary to the health interests, due to the effect and intricacy of the issues on the national public opinion and the stability of the political situation in the country. The history of politics in the Agency witnesses and confirms the drastic hazardous effects of politics on the flow of work and achievements of the Agency. At present, the case of Eastern Mediterranean and the Communist Bloc are the most outstanding political issues in the World Health Organization.

The growth of national participation in health matters reflects some of the political and ideological forces at work in the World. These forces hampered the effectiveness of national participation on health collaboration either by their refusal to participate or by their active withdrawal from the Organization due to the ideological cleavages in the world community.

> The broadened concept of World Health which the World Health Organization had adopted and the increased range and capacities of that organization have projected world health into the area of World Politics at a number of points. These points are to be treated primarily as Organizational, economic and ideological issues.[24]

The most prominant organizational issue have arisen in respect of the long strenuous effort to unite all international health work within a single universal institution. At the Health Conference, a controversy on the organizational set up occurred, when the United States, Latin American Republics and the Arab states had favoured the establishment of a loose federation in which the regional organizations will be endowed with considerable operational autonomy. The Soviet Bloc and other countries urged for centralization of authority and the absorption of the existing agencies into the World Health Organization. The divergent views were compromised by the integration of the existing regional agencies with the World Health Organization, subject to the general authority of the Central Levels while retaining considerable freedom of action on exclusively retional health matters.

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[24] C.E. Allen, "World Health and World Politics," International Organization, IV (February, 1950), P. 38.

Another profound organizational problem is that of delineation or re-delineation of areas, and the assigning of countries to the established delineated region.

The resistance from countries of the respective regions arose due to political, national or prestige considerations. Many delineated countries requested re-assignment to another region. Greece was initially assigned to Eastern Mediterranean Region, but it insisted on re-assignment to the European Region, as it is an integral part of the European Continent which had higher prestige than any other continent at that time.

Libya, when it became independent, requested re-assignment to the Eastern Mediterranean Region, to be associated with the other Arab states in the Region.

While Israel insisted on assignment to the Eastern Mediterranean Region, the Arab states persistantly refuse to include it due to the political hostility existing between them on the national issue of palestine. The Arab states since 1951 and up till now, succeeded in ousting Israel from the Eastern Mediterranean Region, and this thorny problem of re-delineation of areas, due to political antigonism against a particular state

in the region, remains outstanding and unsolved. Although the constitution empowers the Assembly to re-delineate the areas to avoid organizational handicaps, yet the procedural and structural complications involved make the Assembly delegations reluctant to re-define the areas. The Health Assembly was and still is disposed to re-delineate the Eastern Mediterranean Region so as to exclude Israel, and although the state of Israel was assigned to the Eastern Mediterranean Region, in fact, the assignment is nominal and the Health matters pertaining to the state of Israel are directed and controlled from the Headquarters at Geneva.

The unforeseen political flactuations in the World political system, and the emergence of new hostilities between nations, influence the stability of the planned policies of the World Health Organization in general and the geographical delineations of the regions in particular.

Economic issues of political flavour confronting the World Health Organization are few and infrequent. In an attempt to maintain and preserve the policy of standardized medical products, the United States submitted a proposal empowering the Health Assembly to adopt regulations

preventing the importation of biological, pharmaceutical and similar products which are not in conformity with the established standards. However, the USSR and the Latin American Countries protested against such a provision as it has economic and political implications. The provision is to the advantage of a few highly industrialized states over the many nations with infant drug industries. Consequently the proposal was defeated. The major political powers attempt to exploit the health concept in a political context, favourably and to the advantage of the economy of a certain country.

The most numerous and outstanding issues of world polities affecting the World Health Organization are those governed by ideological cleavages between nations.

An interesting and significant issue of religious flavour, arose in the World Health Organization over a report submitted by a health committee, concerning maternal and infant hygiene. The report recommends the use of drugs to prevent pregnancy in cases of ill health. However, a number of nations, particularly those of fanatic catholic affiliations, insisted on the revision of the report as it offends the religious beliefs and moral and legal principles.

Another issue entailed the question of responsibility of the World Health Organization in the field of health insurance. Despite the unanimous agreement of members to the improvement of medical care for low income groups, opposition in particular by the United States arose against the entanglement of the World Health Organization in the socialized medicine. On the other hand, other European nations and especially the Scandinavians who have a national insurance health scheme argued that health and social security are interchangeable and inter-related and the World Health Organization should promote and bolster such matters. Finally a compromise was reached confining the role of the World Health Organization in social security matters to the fact finding, analysis and reporting.

The political flavour permeating over the universe and captivating the minds of the rulers is widening the split between nations and hindering cooperative endeavours even in constructive fields such as health. The ideological cleavage between the East and West had and is still having serious repercussions on the members of the Agency. Further, the individual national or territorial conflicts between nations, in addition to the world wide tension and cold war between

the Eastern and Western Camps, make political problems a serious and continual hindrance to the United Nations System in general, and the specialized agencies in particular. Numerous issues of tensions and conflicts between countries or within the country itself may be given. The following may be cited:

1. The national conflicts between India and Pakistan on Kashmir.
2. The border conflict between India and China.
3. The border conflict between Algeria and Morocco.
4. The Palestinian Issue.
5. The physical split of Germany into Eastern and Western Germany.
6. The physical split of Vietnam into Southern and Northern Vietnam.
7. The physical split of Korea into Southern and Northern Korea.
8. The physical split of China into Communist and National China.
9. The Ideological conflict between Cuba and the United States.

The tensions and conflicts existing between nations are real detriments to the progress and cooperative

endeavour of the World Health Organization. For example, if the Agency plans to carry a project in the neighbouring countries of India and China or in any of the physically divided countries, the participation and cooperation of the two hostile countries is indispensable for the success of the project, but the tension and conflict between the countries deem the project to inevitable failure. A genuine and concrete issue, which has been going on since 1948, is the case of the Eastern Mediterranean.

Many political or national issues cannot be ignored and considered as secondary to the health interests, due to the intricacy and delicacy of the issue on the local and world public opinion in general and the political stability of the country in particular. The most realistic example is the Palestinian issue and its ethical and national meaning to the Arab World.

> The controversy which has virtually paralized the question of the regional committee for the Eastern Mediterranean is one of the most serious which has confronted the World Health Organization since its foundation. The quarrel was political in origin and its roots lay well outside the World Health Organization because of WHO's decentralization, however, and the large responsibilities attaching to regional organization in WHO's operation, the effects of the controversy were more serious in WHO than would have been the case in any other international organization.[25]

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[25] Robert Berkov, The Work of the World Health Organization: A Study in International Decentralized Administration (Geneva: Librairie E. Droz, 1957), P. 133.

Subsequent to the rise of the alleged state of Israel in usurped Palestine in 1948, Israel was admitted to the World Health Organization as a full fledged member and the state of Israel was delineated to the region of Eastern Mediterranean whose regional office is at Alexandria, United Arab Republic.

In 1951, the Arab States reached to a unanimous decision of affecting a policy of economic blockade and complete boycott of the alleged state of Israel. The resolution stipulated that Arab States should refrain from cooperating with Israel and refuse to convene with their representative to the World Health Organization in sessions of the Regional Committee, and ever since no sessions have taken place. The action of ousting the state of Israel from the region meant that the budget estimates and program formulations accounted for Israel in the allotments of the Eastern Mediterranean region caused an unpredicted drastic change in the financial and operational activities of the World Health Organization. The regional Committee for Eastern Mediterranean was deplored to disregard its political sympathies, but all endeavours were fruitless.

Restless attempts to solve the deadlock in the Eastern Mediterranean were undertaken. A proposal to transfer Israel to the European Region was made, but Israel refused. Another proposal stipulated that two sub-committees A & B to the Regional Committee would be created and representatives from each of the sub-committee would meet to consolidate and coordinate their reports. However, the Arabs refused to delegate a representative for the consolidation of the report and finally it was agreed that negotiations would be by means of correspondence and consultation.

At this juncture, Israel objected on the grounds that meeting by correspondence is against the constitution of the World Health Organization. Consequently the action was deferred.

> The Seventh Assembly, meeting in May 1954, adopted a new formula. It proposed again the establishment of two sub-committees, expressed the hope that as many countries as possible would participate in both sub-committees, approved a detailed procedure for the meeting of both sub-committees, and declared that if only one of the sub-committees were able to meet, its opinions should be transmitted to the Executive Board. This proposal encountering no objection, it was duly passed by the Assembly.[26]

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[26] Official Records of the World Health Organization, The Seventh Report of the World Health Assembly, No.55 (Geneva, 1954), P. 12.

Since 1954, and up till now, Israel constantly absents itself from the meeting of Sub-committee B and consequently is cancelled. The views of Sub-committee A, which are transmitted to the Executive Board and the Health Assembly, represent the formal view of the Regional Committee of Eastern Mediterranean Region. The delegate of Lebanon expressed an opinion in this respect stating, "We can now conclude that this sub-committee represent the Regional Organization of the Eastern Mediterranean as a whole, mainly due to the absence of sub-committee B, and that its resolutions should be considered as coming from the Regional Committee itself."[27]

The health operations for the State of Israel are planned and conducted from Geneva and the Health Assembly in its annual meeting continuously hopes that the resolution of the Seventh Assembly would be duly implemented.

Another outstanding political issue of a universal character is the past and present role of the Communist Bloc in comparison with the Western Bloc in the World Health Organization.

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[27]Official Records of the World Health Organization, The Eighth Report of the World Health Assembly, No. 63 (Geneva, 1955), P. 426.

> Cooperation at the international level continues to be a most difficult and complex problem. Since it is impossible to divorce political matters from health considerations, the existance of rivalries, fears and competition accentuated by the East-West split, inevitably poses handicaps and barriers which the United Nations has been unable to overcome. It is too much to expect that there will be greater success in cooperative ventures through the United Nations until there is a considerable lessening of political tensions.[28]

At this stage, it is essential to envisage and trace the historical development of political forces in the World Health Organization and the manifestation of the political motives of the Soviet Bloc.

> The Organization received a serious set back at the end of the year 1949, when one of its member states, Bulgaria gave notice of its withdrawal from active participation. This fact is recorded with regret, since Bulgaria together with the other non participating members the USSR, Byelorussia SSR, and the Ukrainian SSR, could usefully contribute to the knowledge and experience necessary for the building up of services to assist an ever increasing number of people throughout the World. The withdrawal seems to mark a step away from needful international cooperation and from the one world concept that seem basic to the health and happiness of mankind.[29]

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[28] Goodspeed, Op. cit., P. 454.

[29] Official Records of the World Health Organization, The Work of WHO: Annual Report of the Director-General to the World Health Assembly and the United Nations, No. 24 (Geneva, 1949), P. viii.

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The withdrawal of the U.S.S.R. was followed by a series of withdrawals by its Satellites, so that in 1950 the following have withdrawn and were labled as inactive members: Albania, Bulgaria, Byelorussia SSR, U.S.S.R., Czechoslovakia, Hungary, Poland, Roumania, and Ukranian SSR.

The impact of the withdrawal of U.S.S.R. and its satellites from the World Health Organization on the 17th of February, 1949, was shocking as this was the first withdrawal from an Agency of the United Nations System since its foundation.

The justification given by the withdrawn members was that the work of the World Health Organization on control of disease and dissemination of medical knowledge was unsatisfactory and does not worth the expenses incurred for a continued membership. However, the decision to withdraw was not probably due to health or Organizational grievances but was a consequence of political considerations.

During the first two years, the U.S.S.R. vigorously cooperated with other members in a number of cases. The Russian attitude changed abruptly and was manifested in a bitter attack on the World Health Organization. The

motive as revealed from the argumentation of the attack was directed against the Western Bloc in general and the capitalistic system in particular, and it used the health apparatus as a means to propogandize its ideological beliefs. The U.S.S.R. accused the World Health Organization of prejudicial attitude as its work had been deficient to give substantial aid to countries of the Communist Bloc. Further, the Agency wasted huge sums on its subordinate bodies instead of providing funds and medical supplies. The Soviet Bloc made it clear that it wanted more goods and money and less advice. However, the theme of the attack had a clear underlying aim of political flavour. The accusation and criticism of the Work of the Agency as superficial was based on the premise that the World Health Organization neglected the real causes of disease which lie in the social and economic structure of various countries. In colonial areas, the source of epidemics was poverty which results from imperialist exploitation. In more industrialized countries, the spread of disease was a natural outgrowth of capitalism. The Soviet Bloc claimed success in coping with such deficiencies as its health services were organized to provide adequate medical care to the entire population on an equal bases irrespective of social stratification and economic

differences. Hence the U.S.S.R. proposed that the World Health Organization can achieve its mission by promoting a policy of gradual nationalization of health services and important medical industries.

Despite these assertions, the real reasons for the subsequent Russion withdrawal suggested that the impetus was inspired more by political motives than by dissatisfaction with the work of the Agency. The attitude of one of the world powers constituted a real threat and a serious challange to international collaboration for health services. The periodic withdrawal of the Soviet Satellites was based on the charge against the policy of the United States to deliberately withhold technical information about the manufacture of drugs and medicines.

The stagnation in the active participation of the Soviet Bloc dragged on for several years, till in 1955, the U.S.S.R. decided to resume active membership as it realized that the tangible benefits in aid and supplies from the Organization in relation to its quota contribution is not the most important thing. The prestige acquired from being an effective member in an international organization, the indispensibility of health organizations and services, the need for international collaboration against the many social, economic and health evils of the

world - all these factors stimulated the Soviet Bloc to resume active membership. At present, Appendix G, the statement of outstanding contributions for 1962 and prior years, indicate that Byelorussia SSR, Hungary and Ukranian SSR are still labelled as Inactive Members with a total outstanding Balance of $3,302,657.

Despite the susceptibility of the field of health to the forces of world politics, yet the imperativeness and universality of practical cooperation, due to technological advances, is indispensable. The U.S.S.R. during the period of withdrawal, engaged in limited and informal health matters.

> The sheer need to cooperate will probably nourish the growth of World Health Institutions. This growth will be conditioned perhaps critically, by the climate of world politics, unless the political climate worsens drastically. However, the World Health Organization will be able to contribute much to human well being, and by its example, may stimulate effective international cooperation in other fields.[30]

However, it is worth mentioning that:

> Until political tensions subside, and until fundamental political agreement

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[30] Allen, Op.cit., P. 43

is reached, there is little possibility that greater economic and social cooperation will take place. More and more have the Specialized Agencies and Economic and Social Council been drawn into the political arena of the East-West conflict.

It appears that economic and social cooperation will not increase to any degree until the political climate of International relations is ready for it. When global rivalry exists to the extent that it does today, there is virtually no activity which can be labelled non-controversial and non-political.[31]

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[31] Goodspeed, Op.cit., P. 506

PART III

FINANCIAL AND PERSONNEL ADMINISTRATION IN THE WORLD HEALTH ORGANIZATION

CHAPTER IV

THE FINANCIAL ASPECTS OF THE WORLD HEALTH ORGANIZATION

A General Survey

The financial policy of the World Health Organization is governed by Financial Regulations which lay down the general underlying principles of the budgetary cycle and sources of finance to the Agency.

The budget, is the steering instrument of the Organization which outlines and controls the future operations and plans of the Agency. Thus, a detailed and scrupulous analysis of the financial policies of the World Health Organization reveals the scope and extent of the functions executed and the obstacles encountered by the Agency.

The Executive Board by virtue of Article 28(g) of the Agency's Constitution is requested to submit to the Health Assembly a general program of work covering a specific period of time, for consideration and authorization. The program is approved for a period of four years and provides a broad general policy as an appropriate framework for the development of the detailed annual program.

> The general program sets out the scope of WHO activities, and is used as a guide to determine the suitability of particular proposals for WHO action. The general program of work is not of course, a budget, it is rather, a long-range projection of policy, on which the Director-General's annual budget proposals must be based. It is the duty of the Executive Board, and eventually of the Assembly, to determine whether such budget proposals conform adequately to the general program.[1]

The first motive for the preparation of a general program to cover a specific period of time was initiated in 1948. The Director-General in the light of his proposed program formulations and budget estimates, submitted to the Executive Board a general program entailing a long range plan extending over several years.

An annual plan is developed within the context of the long-range plan to encompass a fixed plan of work which could be accomplished in a calender year. The Executive Board designed and modified the program and consequently transmitted it to the Health Assembly for consideration and authorization. The Health Assembly approved the program in 1951.

The plan was based on the following general principles of the Agency:

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[1] Robert Berkov, The World Health Organization: A Study in Decentralized International Administration (Geneva: Librairie E. Droz, 1957), P. 90.

1. All countries and territories should take part in organization's work.

2. Assistance to a government in the development of its health services should be supplied only on the request of the government concerned.

3. The services afforded should be calculated to foster national and local self-reliance and initiative and should be adapted to the environment.

4. The organization should limit its efforts on behalf of research to stimulating and coordinating current efforts.

5. Services should be available to all member states.[2]

The selection or rejection of the activities proposed by the Executive Board is, however, governed by certain criteria. The program should be internationally feasible to gain the approval of the Organization and must yield demonstrable results which should benefit directly or indirectly the largest number of countries or people. The country in which the program is implemented should have the necessary potentialities of staff and facilities to resume the work after the completion of the initial stages of the program and departure of the experts and initiators of the program. A reconnaissance survey should preceed any commitment of approval on a proposed program.

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[2]World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 113.

The preliminary study should indicate that a previous research work has been done on the subject and financial sources, other than the United Nations and the Specialized Agencies, are available. Further, the proposed plan of work should give evidence and a sound justification stipulating that the World Health Organization is the most plausable institution to do the work, and references and literature on the subject are also available.

> Finally, the Board pointed out that in the prevailing financial stringency only the careful application of these criteria would make it possible to select those activities which would ensure the optimum utilization of the funds available.[3]

The second long range general program for the four years 1957 - 1960, was proposed by the Executive Board in January 1955 and approved by the Health Assembly with some modifications.

The Budget Process

"The planning, development and implementation of the WHO Program for a single year extends over a period of three years which are administratively referred to as the planning, approving and operating years."[4] Thus the

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[3] Ibid., P. 114.

[4] Berkov, Op.cit., P. 90.

preparation of the annual program and budget estimates, commences nearly two years before the financial year during which the program is to be executed.

The planning year is initiated by the Director-General immediately after conclusion of the sessions of the World Health Assembly. The Director-General sends a directive to the heads of departments and offices at Headquarters and Regional Offices urging for proposals and policy considerations to be accounted for in planning the program of work, along with an indication of the tentative allocation of funds and budget estimates. Simultaneously, the Regional Directors consult with the respective governments in the areas and obtain their consent for assistance. On the basis of the requested assistance, the Regional Directors lay preliminary plans of the regional programs, after scrutinizing the proposed projects, in order to determine their feasibility and to coordinate them in a plan of development in conformity with the general program of work and budgetary implications based on the regional allocations of prior years. The plans and programs of other agencies operating in the region are also taken into account in order to find out if the cost of their execution is within the tentative allocations of the region. The cost of the project is

estimated and consolidated in the regional program which is submitted to the Regional Committee for further scrutiny.

The Director-General is entrusted with the responsibility of proposing the annual budget estimates of the World Health Organization. Article Thirty-Four of the Constitution of the Agency stipulates that "The Director-General shall prepare and submit annually to the Board the financial statements and budget estimates of the Organization."[5] However, he is entitled to delegate this prerogative to the Regional Directors and Committees, as they are nearer to the place of operations thus enabling them to provide more genuine and original recommendations on the activities of the region and the pressing needs of the people.

> Preliminary regional planning commences before the convention of the Regional Directors with the Director-General and continues after the return of the Regional Directors to their regions from the Health Assembly. The program needs of the various regions are estimated, analyzed, evaluated and converted into budgetary terms. The findings are proposed and submitted by the Regional Directors to their respective Regional Committees for further consideration.[6]

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[5]World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 10.

[6]Berkov, Op.cit., P. 90.

The regional committee scrutinizes the comments and recommendations of the regional director and pays particular attention to requests of governments in the area and to projects in which more than one country is involved. Subsequently, the proposed program and budget estimates for the region are communicated to the Director-General along with the comments and recommendations of the regional committee.

The Director-General and his staff at Headquarters review, consolidate and assemble the proposed program and budget estimates submitted by the regional offices and departments at Headquarters and decides which activities are to be incorporated in his proposed program and budget estimates for the year.

The Director-General, in January of the next year submits the proposed program and annual budget estimates to the Executive Board for a detailed examination and comments. The Standing Committee on Administration and Finance of the Executive Board, in May or June, submits the proposed program and budget estimates along with its comments and recommendations to the World Health Assembly.

The approving year commences with the submission of the proposed program and budget estimates to the World Health Assembly for a meticulous examination and scrupulous scrutiny of the recommendations of the Executive Board. The World Health Assembly by a simple majority vote either approves the report of the Director-General on the budget or modifies it in the light of the opinions expressed by the Assembly delegations.

Upon approval of the Assembly, the authorized budget will be appropriated during the operating year.

The Director-General, in his report of proposed program and budget estimates, includes in addition to the regular program, other programs which are differently financed. The programs can be classified into three types of financial management. Programs fully financed by the World Health Organization, programs jointly financed with the World Health Organization, and programs which are fully financed by other organizations or institutes. Illustrations of such programs are: The United Nations Expanded Program of Technical Assistance for Economic Development of Under-developed Countries, Activities assisted jointly with UNICEF, proposals for activities to be financed by the Pan American Sanitary

Organization, and from the Malaria Eradication Special Account.

Supplementary estimates consistent with the annual budget estimates may be submitted to the Executive Board by the Director-General, whenever an increase in the amounts appropriated by the World Health Assembly is deemed necessary.

The Sources of Finance

The provision of funds to meet the appropriated sums are financed from the several sources of revenue which the Agency receives. Pending the receipt of contributions from the members, the appropriations are financed from the Working Capital Fund.

Article Fifty-Six of the Constitution of the Agency assesses fixed contributions on members which are regularly remitted to the Agency every year. It states that "Subject to agreement between the Organization and the United Nations, the Health Assembly shall review and approve the budget estimates and shall apportion the expenses among the Members in accordance with a scale to be fixed by the Health Assembly."[7]

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[7] World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 14.

The amounts assessed on members, as per the scale of assessment for 1962, 1963 and 1964 showed a total of $ 24,148,320; 30,884,570 and 34,639,550 respectively.

The other sources of income to the Agency, based on voluntary contributions by governments, represent an element of risk and uncertainty to the planning policy of the Agency's activities. The Financial Regulations of the World Health Organization stipulate:

> The funds placed at the disposal of the Agency under the United Nations Expanded Programme of Technical Assistance and a Special Fund for Malaria Eradication. Other minor sources classified under 'Casual or Miscellaneous income', constitute endowments and gifts, receipts from sales such as publications, fees for services rendered, annual contributions of unofficial bodies or institutions as a donation subscription because they persue the same objective, and finally interest rates earned on investments.[8]

The amounts received by the World Health Organization under the Expanded Programme of Technical Assistance depends on the voluntary subscriptions of the governments to meet their obligations.

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[8] Ibid., PP. 73 - 75.

> The voluntary contributions to the Malaria Eradication Special Account from inception have (as at 31 December 1962) reached the amount of $ 17,826,125, of which the U.S.A. has contributed $ 15,000,000. The additional amount of credits of $ 2,883,950 was derived from the amount appropriated for 1962 from the regular budget ($ 2,000,000), interest earned, proceeds from the Malaria Eradication Postage Stamp Project and miscellaneous income bringing total credits to $ 20,710,075 as at the end of 1962.[9]

The Malaria Eradication Special Account was established by the World Health Assembly in 1955. The voluntary contributions to the fund are collected by the Committee on Malaria Eradication on behalf of the Executive Board. The Director-General is authorized to utilize the Fund for research costs, necessary supplies and equipment and services required in individual countries not available by the government.

The contributions for accomodation purposes formulate an unforeseen source of revenue to the capital assets of the Agency. The Headquarters at Geneva was accomodated by the goverhment of Switzerland. The Regional Offices at Manila, Alexandria, and Copenhagen were accomodated by the government of Philippines, United Arab Republic, and Denmark.

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[9] Official Records of the World Health Organization, Financial Report: 1 January - 31 December, 1962, No. 126 (Geneva, 1963), P. 89.

The United Nations Children's Fund, known as UNICEF, cooperates and assists the International Health Programs launched by the World Health Organization. Large sums are appropriated by the United Nations Children's Fund to projects jointly carried out with the World Health Organization for the benefit of the health of mothers and children.

The Publishing Revolving Fund is replenished by the sales from publications of the World Health Organization and is utilized to meet the cost of printing the publications for sale and some incidental expenses. The Fund is reviewed annually by the World Health Assembly and the excess is transferred to miscellaneous income.

The Working Capital Fund is determined after the adoption of the budget by the World Health Assembly. The Director-General transmits the approved budget to the state members, informs them of their commitments in the light of the scale of assessments and requests the remittance of their contributions and advances. Remitted payments will be credited first to the Working Capital Fund and then to the contribution account due from the members in accordance with the scale of assessments.

The Working Capital Fund, as the name implies, is primarily a Fund for contingencies to meet unforeseem or extraordinary expenses. The Fund finances the work of the Agency pending the receipt of the contributions from member states.

> The bulk of the Fund is determined by the Health Assembly and the share of each member is in accordance with the fixed scale of assessments. Borrowing from the Fund is permissable provided they are reimbursed upon the receipt of the contributions from the respective members. The income derived from the investments of the Working Capital Fund, is credited to the miscellaneous income account.[10]

Trust Funds, Reserves, and the Special Accounts which are determined and limited by the appropriate authority, are established by the Director-General and reported to the Executive Board.

Article VII, of the Financial Regulations of the World Health Organization stipulates: "All other income, except contributions to the budget, direct refunds of expenditures made during the financial year, and advances or deposits to funds shall be classed as miscellaneous income, for credit to the General Fund."[11]

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[10] Ibid., P. 127.

[11] World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 75.

Gifts or bequests, financial or non financial, may be accepted by the Director-General provided that they are consistent with the terms of Article 57 of the Agency's Constitution which states: "The Health Assembly or the Board acting on behalf of the Health Assembly may accept and administer gifts and bequests made to the Organization provided that the conditions attached to such gifts or bequests are acceptable to the Health Assembly or the Board and are consistent with the objectives and policies of the Organization."[12]

Specified donations by donors are credited to the Trust Funds or Special Accounts. Unspecified donations are credited to a special account established under the specified purpose of the fund.

The Execution of the Budget

Rule Ninty-Three of the Agency's Rules of Procedure stipulate: "The Health Assembly shall, at each regular session, adopt the budget authorizing expenditure for the next financial year after consideration of the Director-General's budget estimates and the Board's recommendations thereon."[13]

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[12]World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 469.

[13]World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 119.

The Fourth Article of the Financial Regulations of the World Health Organization provide that the appropriation resolution initiated by the World Health Assembly represent an authorization to the Director-General to carry out the programs, incur financial obligations and make payments within the appropriated voted sums. Further, it provides that:

> Appropriations shall be available for obligation for the financial year to which they relate. The Director-General is authorized to charge the following as an obligation against the annual appropriations:
>
> 1. The costs, including transportation of operational supplies, and equipment for which contracts have been entered into prior to 31 December of the financial year;
>
> 2. The cost of publication for which completed manuscripts shall have been delivered to and received by the printer prior to 31 December of the financial year;
>
> 3. The entire costs relating to short term consultants whose period of assignment may not have been completed by the end of the financial year;
>
> 4. The full estimated cost of a fellowship.[14]

The incurrance of any obligation or financial commitment in the region is done as soon as the regional

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[14] Ibid., P. 72.

offices receive the specified allotments. The Regional Directors implement the operations of the particular projects and programs specified in their budget proposals upon the receipt of the allotments from Headquarters.

A compilation of a detailed plan of operations for the projects appropriated in the regional budget, along with a justification and estimates of the activity based on the latest available information are submitted by the respective regional offices to the Headquarters for allotment of the funds and subsequent authorization to incur obligations.

The submitted request is carefully checked and reviewed at Headquarters. The scrutiny of the request is made in the light of the regional budget proposals and is then passed for further examination in accordance with the initial appropriation resolution initiated by the World Health Assembly, the financial regulations and the general policy of the World Health Organization. Once the submitted request reconciles with the Financial rules and regulations, the budgetary provisions and other applicable directives of the Agency, it is followed by the shaping of the allotments to the respective regional offices. However, all financial commitments which are to be made by the regional directors should be in

accordance with the items and specifications of the annual program. The control of the financial aspects at the regional level becomes the responsibility of the regional offices which decide, analyze and control all obligations to be incurred against the allotments within the maximum amount appropriated for a specific activity.

Financial statements and records should be maintained by the regional offices indicating the initial amounts alloted and the obligations incurred for external audit purposes.

The regional directors are endowed with an authority to commensurate with their regional responsibility for execution of the approved program of the World Health Organization in the region. The authority is manifested in their eligibility to make financial commitments for all purposes, including the granting of awards for fellowships, provided they are covered by the allotments.

The allotments to carry out an activity may prove insufficient. However, discretionary alterations in the amounts earmarked for expenditure either due the inadequacy of the allotments or to unforeseen circumstances, cannot be initiated by the Regional Director. The shortage in

the day to day expenditures to finance the execution of an activity, due to unpredictability of the exact funds, can be remedied by submission of a request accompanied by a detailed justification to the Director-General for his reconsideration in order to increase the alloted amounts. Similarly, an excess in the amounts alloted for an activity can be transferred by the Director-General either back to the Headquarters or to other projects in the same or other regions.

> At fixed periods the status of allotments is reviewed and analysed in the regional offices and reported to Headquarters, which strives to assure two conditions: One, that the amounts are adequate for the purpose intended; two, that funds are not unnecessarily earmarked for a particular purpose or project if they are not required for the correct financial year.[15]

The Budget

In order to understand the work of the World Health Organization at Headquarters and in the regions, a detailed analysis of the annual budget will be presented.

The analysis and presentation of the budget of the World Health Organization will be based on the annual budget

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[15] Berkov, Op.cit., P. 93.

for the financial year ending December 1962 since the official Financial Report for the 1962 budget, which gives detailed and accurate analysis of the status of the budget, is issued in April of the next financial year, 1963. However, a comprehensive analysis of the annual budget for the financial year 1963, and the proposed budget estimates for 1964, will be presented.

The budget is the pumping heart of the Agency. A tangible and constant progressive annual increase in the budget of the World Health Organization, since its formation, appears hereunder in Table 2.

TABLE 2

THE BUDGET OF THE WORLD HEALTH ORGANIZATION
FOR THE FISCAL YEARS 1951 - 1962*
(Expressed in US DOLLARS)

Years	Effective Working Budget	Undistributed Reserves	Original Amount Voted	Revised Appropriations
1951	-------	-------	7,300,000	7,677,401
1952	7,667,782	1,400,000	9,077,782	9,077,782
1953	8,485,095	1,347,659	9,832,754	9,832,754
1954	8,497,700	1,340,300	9,838,000	9,838,000
1955	9,500,000	1,499,360	10,999,360	10,999,360
1956	10,203,084	1,871,060	12,074,144	12,074,144
1957	12,207,760	1,057,660	13,265,420	13,590,420
1958	13,566,130	1,203,030	14,769,160	14,769,160
1959	14,949,966	1,078,060	15,365,660	16,028,026
1960	16,918,700	1,195,060	18,113,760	18,113,760
1961	18,975,354	1,333,900	20,309,254	20,309,254
1962	23,607,180	1,683,140	25,290,320	26,546,940

*Official Records of the World Health Organization, The Work of WHO: 1962 Annual Report of the Director General to the World Health Assembly and to the United Nations (Geneva, 1951 - 1962).

The increase in the Budget is attributed to many considerations. It reflects primarily a good gesture and favourable expression by member states of their greater consciousness, recognition and participation in the attainment of the aims and objectives of the Organization, and indicates that the members are more aware of the significance of their contributions as matched with the fruitful results realized by the Agency. It is stated that "A small financial outlay can teach less fortunate peoples the rudimantary elements of hygiene and the many other fundamental aspects of ordinary social and economic life which are taken for granted in most of the more advanced countries."[16] Further, the substantial rise in the costs of materials and manpower over the last decade affected the progressive increase in the budget to enable the Agency to cope with the increasing administrative and operational costs.

The financial status of the World Health Organization is gradually gaining an augmanted financial and moral support, due to the humanatarian and material aid which the Agency has awarded to many of the nations in their hazardous days of need. The extensive programs of disease

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[16]Stephen S. Goodspeed, The Nature and Function of International Organization (New York: Oxford University Press, 1959), P. 503.

eradication and the aid to all countries plagued by epidemics, catastrophies or calamities has, substantiated its existance and significance as a symbol of international cooperation and enhanced the financial support by member states.

> The effective working budget for 1962, approved by the Fourteenth World Health Assembly, amounted to $ 23,607,180. The Fifteenth World Health Assembly approved a supplementary budget increasing the budget level by $ 1,256,620, mainly to meet salary adjustments that came into effect for the International Organizations as from January first, 1962. The total working budget for 1962 was thus established at $ 24,863,800. Inter-section transfers amounting to $ 237,233 were made with the concurrence of the Executive Board.[17]

The effective working budget represents the amounts assessed against active members of the World Health Organization in addition to any available revenue from miscellaneous sources. The amounts assessed are in accordance with a scale of assessments fixed by the World Health Assembly for the apportionment of the expenses of the World Health Organization. The regular budget of the Agency does not include the separate budgets made available to the World Health Organization

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[17] Official Records of the World Health Organization, Financial Report: 1 January - 31 December, 1962, No. 126 (Geneva, 1963), P. 87.

in a joint venture.

The regular budget of the World Health Organization for 1962, appearing in Table 3, is divided into Five parts: Organizational Meetings, Operating Programs, Administrative Services, Other Purposes and Reserves.

Each of the Five major parts is subdivided into sub-activities showing the amounts allotted for each activity. The regular budget shows also horizantally, the original amount voted by the World Health Assembly, the supplementary estimates, the transfers concurred and finally the revised appropriated budget.

TABLE 3

THE BUDGET OF THE WORLD HEALTH ORGANIZATION
FOR THE FISCAL YEAR ENDING DECEMBER 1962*
(Expressed in US DOLLARS)

Appropriation Section	Purpose Of Appropiration	Original Amount Voted	Transfers Concurred In By The Executive Board	Supplementary Estimates	Further Transfers Concurred In By The Executive Board	Revised Appropriations
	Part I: Organizational Meetings					
1.	World Health Assembly	283,910	12,100	7,000	---	393,010
2.	Executive Board & Comm.	180,100	4,000	3,950	---	188,050
3.	Regional Committees	123,290	(9,290)	---	40,000	154,000
	Total - Part I	587,300	6,810	10,950	40,000	645,060
	Part II: Operating Programme					
4.	Program Activities	12,219,046	(222,571)	967,920	---	12,964,395
5.	Regional Offices	2,314,257	(53,342)	174,763	73,900	2,509,578
6.	Expert Committees	219,800	2,200	---	---	222,000
7.	Other Statutory Staff Costs	4,033,794	273,934	(133,823)	(113,900)	4060,005
	Total - Part II	18,786,897	221	1,008,860	(40,000)	19,755,978
	Part III: Administrative Services					
8.	Administrative Services	1,480,650	(14,652)	210,312	---	1,676,310
9.	Other Statutory Staff Costs	455,333	7,621	26,498	---	489,452
	Total - Part III	1,935,983	(7,031)	236,810	---	2,165,762
	Part IV: Other Purposes					
10.	Headquarters Building Fund	297,000	---	---	---	297,000
11.	Contributions to the Malaria Eradication Special Account	2,000,000	---	---	---	2,000,000
	Total - Part IV	2,297,000	---	---	---	2,297,000
	Total - Parts I, II, III & IV	23,607,180	---	1,256,620	---	24,863,800
	Part V: Reserve					
12.	Undistributed Reserve	1,683,140	---	---	---	1,683,140
	Total Part V	1,683,140	---	---	---	1,683,140
	Total All Parts	25,290,320	---	1,256,620	---	26,546,940

The obligations incurred during the financial year 1962, under the regular budget, amounted to $ 24,164,650. A statement of the obligations incurred, itemized in accordance with the main activities and sub-activities of the Agency, appears herebelow in Table 4.

TABLE 4

STATEMENT OF OBLIGATIONS INCURRED DURING THE FINANCIAL YEAR, 1962*
(Expressed in US DOLLARS)

Appropriation Section	Particulars		Obligations
1.	World Health Assembly		$ 298,895
2.	Executive Board and Iys Committees		174,555
3.	Regional Committees		144,776
4.	Programme Activities:		
	Headquarters	3,824,988	
	Publications	671,566	
	Field	8,012,366	12,508,920
5.	Regional Offices		2,467,068
6.	Expert Committees		221,448
7.	Other Statutory Staff Costs: Operating Programme		3,906,131
8.	Administrative Services		1,657,389
9.	Other Statutory Staff Costs: Administrative Services		470,468
10.	Headquarters Building Fund		297,000
11.	Contributions to the Malaria Eradication Special Account		2,000,000
			US $ 24,164,650

*Official Records of the World Health Organization, Financial Report: 1 January - 31 December, 1962, No. 126 (Geneva, 1963) PP. 34 & 35.

Concerning the Malaria Eradication Special Account, it is stated:

> The obligations from inception, and credits to members in accordance with the decisions of the Fourteenth World Health Assembly, totalled $ 468,201 leaving a balance as at 31 December 1962 in the Special Account of $ 1,241,874. The proceeds in 1962 of $ 181,303 from the postage stamp project launched in that year, in furtherance of WHO's Malaria Eradication Programme, was credited to the Special Account.[18]

The obligations of $ 24,164,650 incurred in 1962 represent 97.19% (as against 97.07% in 1961), of the effective working budget leaving an unobligated amount of $ 699,150. The following Table gives the obligations incurred in 1962 as compared with those of 1961.

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[18] Official Records of the World Health Organization, Financial Report: 1 January - 31 December, 1962, No. 126 (Geneva, 1963), P. 89.

TABLE 5

STATEMENT OF OBLIGATIONS INCURRED
IN 1961 AND 1962*
(Expressed in US DOLLARS)

	Obligations			
	1961		1962	
	US $ Thousands	%	US $ Thousands	%
Part I - Organizational Meetings	518	2.6	618	2.6
Part II - Operating Programme	16,292	84.9	21,104	87.3
Part III - Administrative Services	1,892	9.9	2,146	8.9
Part IV - Other Purposes	500	2.6	297	1.2
Total	19,202	100%	24,165	100%

*Official Records of the World Health Organization, Financial Report: 1 January - 31 December, 1962, No. 126 (Geneva, 1963), P. 88.

From the above Table, it will be seen that while the percentage of the obligations for the operating programme increased by 2.4 Per cent, that relating to administrative services decreased by 1 Per cent in 1962.[19]

[19] Ibid., P. 88.

Article XI of the Financial Regulations governing the financial policy of the Agency stipulates:

> The Director-General shall maintain such accounting records as are necessary and shall submit annual accounts showing the financial year to which they relate:
>
> (a) The income and expenditure of all funds;
> (b) The status of appropriations, including:
>
> (i) The original budget appropriations;
> (ii) The appropriations as modified by any transfers;
> (iii) Credits, if any, other than the appropriations voted by the Health Assembly;
> (iv) The amounts charged against those appropriations and or other credits;
>
> (c) The assets and liabilities of the Organization.[20]

The above responsibilities of the Director-General are illustrated in Appendixes D, E and F respectively.

Appendix D, gives a consolidated statement of the income and expenditure of funds during the fiscal year, 1962. The account of the Working Capital Fund was established by assessments on members and the Holding Account holds the appropriations available to the World Health Assembly. "Of the balance at 31 December 1962 ($ 1,404,943), $ 500,000 has been appropriated as casual

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[20] World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 77.

income to finance the 1963 budget. The balance of $ 904,943 which is available for appropriation, represents assessments on new members of $ 48,100 and 1962 miscellaneous income."[21]

The Assembly Suspense Account is credited by all cash surpluses accruing during the current financial year from contributions paid in arrears after the full reimbursement of the Working Capital Fund.

> The Revolving Sales Fund is credited with the proceeds from sale of publications, international certificates of vaccination, films and other visual media, and is charged with the cost of reprinting these items. During 1962, an amount of $ 118,599 was transferred to Miscellaneous Income, leaving a balance of $ 40,000 in this account.[22]

Appendix E, illustrates the statement of appropriations, obligations and balances for the year 1962.

> The total obligations amounted to $ 24,164,650, leaving a budget surplus of $ 699,150, equal to 2.81 Per cent of the effective working budget. This surplus does not take into account the undistributed reserve of $ 1,693,140 equalling the special assessment of China and assessments against the inactive members.[23]

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[21] Official Records of the World Health Organization, Financial Report: 1 January - 31 December, 1962, No. 126 (Geneva, 1963), P. 7.

[22] Ibid., P. 8.

[23] Ibid.,

Appendix F, presents a statement of assets and liaibilities of the World Health Organization for 1962. Funds in all currencies are credited to cash after their conversion into the official currency in accordance with the official rates of exchange.

> The cash on deposit amounted to $ 12,850,000. There are also Swiss Securities costing $ 2,773.08 and 2,291.83 that are held respectively on behalf of the Darling Foundation, and other securities costing $ 2,270.35 belonging to the Health Insurance Funds. The total interest earned in 1962 was $ 436,272 of which $ 252,645 is credited to Miscellaneous Income, $ 96,067 to the Malaria Eradication Special Account and the balance to other various funds and special accounts.[24]

The total amount of the accounts receivable represent amounts due from other international organizations, loans to staff members, deposit accounts and other sundry debtors. The voluntary contributions in kind and services represent the undrawn donated stocks of vaccins, drugs, supplies and equipment and others. Finally, the Capital Assets represent the value of the Agency's property in the Regional Office of Africa which was donated by the French Government.

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[24] Ibid., P. 6.

TABLE 6

OBLIGATION FOR PROJECT COSTS

UNDER THE EXPANDED PROGRAMME OF TECHNICAL ASSISTANCE

FOR THE YEARS 1961 AND 1962*

	1961	1962	(Decrease) Increase
Personnel Services	$ 3,005,031	$ 3,979,327	$ 974,296
Supplies and Materials	231,838	313,280	81,442
Property and Equipment	292,925	116,411	(176,514)
Travel and Transportation	821,149	983,901	162,752
Fellowships	1,245,388	1,941,923	696,535
Total	$ 5,596,331	$ 7,334,842	$ 1,738,511

*Official Records of the World Health Organization, Financial Report: 1 January - 31 December, 1962, No. 126 (Geneva, 1963), P. 92.

> As at 31 December 1962 savings on prior years' unliquidated obligations amounted to $ 24,799, which amount for the Expanded Programme of Technical Assistance. In 1962 the unliquidated obligations were $ 1,577,623, mainly representing outstanding balances of fellowships awards where the fellows had not finished their studies by the end of the year. The comparable amount for 1961 was $ 920,633.[25]

The status of the Working Capital Fund in 1962 was determined by the Thirteenth World Health Assembly. It was decided that advances to the Fund should be based on

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[25] Ibid., P. 92.

the 1961 scale of assessment and the amount of $ 4,000,000 plus all assessments on new members should be established. Further, additional advances should be payable prior to December 1963 and credits to members should be reimbursed not later than January 1964. "The credits due to members under this arrangement, amounting to $ 196,885, have been transferred to Trust Funds. The additional amounts due by members amounted to $ 783,303, of which $ 502,425 had not been paid as at 31 December, 1962."[26]

> The unliquidated obligations of $ 2,776,014 represent the estimated amount required to liquidate outstanding liabilities pertaining to the 1962 budget. Included in this amount is $ 1,129,465 for the outstanding balance of 1962 fellowship awards. Fellowship balances brought forward of $ 35,495 represent the estimated amounts required to complete fellowships for printing and operational supplies.[27]

Other accounts payable represent the unliquidated obligations of the Malaria Eradication Special Account, the Voluntary Fund for Health Promotion and the Headquarters Building Fund. Staff members' credit balance and invoices for supplies and services rendered by other organizations add to the liability side of the statement.

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[26] Ibid., P. 88.

[27] Ibid., P. 6.

The difference, between the obligations of $ 24,164,650 incurred in respect of the financial year 1962, and the budgetary income in cash of $ 23,581,711, represent the annual deficit of $ 582,939 which was advanced from the Working Capital Fund. The deficit in 1961 stood at $ 468,294.

A presentation of the budgetary deficiency for 1962 is shown in Table 7.

TABLE 7

STATEMENT OF INCOME AND EXPENDITURE
FOR THE FINANCIAL YEAR, 1962*
(Expressed in US DOLLARS)

Income		
Contributions Received		$ 21,183,091
Casual Income Appropriated:		
Miscellaneous income, 1960	448,280	
Assessments on new members	51,720	500,000
Amount reimbursed by the Expanded Programme of Technical Assistance for Administrative and Operational services costs		642,000
Supplementary Appropriations		1,256,620
	Total	$ 23,581,711
Obligations		24,164,650
Balance-Deficit advanced from Working Capital Fund		$ 582,939

*Official Records of the World Health Organization, No. 126, Financial Report: 1 January - 31 December, 1962 (Geneva: April, 1963), P. 19.

The cost of the decentralized policy implemented by the World Health Organization constitutes a tangible portion of the regular budget expended on the regions. Out of the obligations of $ 24,164,650 incurred in 1962, an aggregate amount of $ 10,624,200 was charged to maintain the field operations. The sum represents the amounts expended on regional committees and offices. However, it should be emphasized that many administrative functions are delegated by Headquarters to the regional offices, which need additional staff and expenses to discharge the prescribed functions. The operating nature of the World Health Organization necessitates the appropriation of significant amounts for expenditure by the regional offices to render services to national governments and execute and coordinate the field projects.

The elimination of the field offices or reduction in the funds allocated in the budget, in an attempt to economize or to centralize the operations of the Agency, might reflect serious repercussions on the efficiency and effectiveness of the World Health Organization or show a significant increase in the administrative expenses of the Headquarters.

"Two additional elements have dominated the selection of programmes for 1963. One is the need to train more and more national health workers of all kinds. The other is the continued expansion of the research activities of the organization."[28]

The effective working budget proposed for 1963 stood at $ 27,550,000 representing an increase of $ 3,845,620 or 16.22 per cent, over the 1962 budget. $ 2,000,000 of the increase were reserved for the Malaria Eradication Programmes in the fields.

The appropriation resolution for the financial year 1963 showed an effective working budget of $ 29,965,000. The amount of the undistributed reserves for 1963 stood at $ 2,149,570, thus adding to the annual budget to stand at $ 32,105,570. The increase in the 1963 budget over last year's budget was appropriated to project activities, additional statutory staff costs, medical research activities, additional accomodation for the Regional Office of Africa and strengthening of certain functions at Headquarters.

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[28] Official Records of the World Health Organization, Proposed Regular Programme and Budget Estimates for the Financial Year 1 January - 31 December, 1963, No. 113 (Geneva, 1961), P. xiii.

The revised estimates of expenditure within the approved effective working budget for 1963, expressed in Dollars, tatalled $ 29,956,000. Further, the amount of $ 162,000 of unforeseen additional expenses raised the budget estimates to $ 30,118,000.

"The guiding policy in the preparation of the annual programme and budget is that of an orderly growth based on the increasing assistance required by governments and on the expansion of the services the Organization has to provide to all members."[29]

The Agency, after a long period of experience in the field of health realized that long term activities, secure maximum self sufficiency of health services and success of health measures. Moreover, the strengthening of national health administrations ranked next in planning the long term programs of the Organization.

The Fifteenth World Health Assembly in discussing the matter stated that "in developing countries, the creation of a network of minimum basic health services

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[29] Official Records of the World Health Organization, Proposed Regular Programme and Budget Estimates for the Financial Year 1 January - 31 December 1964, No. 121 (Geneva, 1962), P. xiii.

must be regarded as an essential pre-investment operation, without which agricultural and industrial development would be hazardous, slow and uneconomic."[30]

"The effective working budget proposed for the fiscal year 1964 is $ 33,716,000, representing an increase of $ 3,598,000 (11,95%) over the 1963 level."[31]

Out of the total increase of $ 3,598,000, the sum of $ 1,363,000 was apportioned to meet the pressing needs of the less developed countries, additional statutory staff costs, expansion in the medical research programme, purchase of capital assets to the new Headquarters building and for the replenishment of the Working Capital Fund to cover the additional accomodation cost for the Regional Office of Africa.

Table 8, gives a comparative tabulated analysis, compiling the total budgets, income assessments and effective working budgets for the financial years 1962, 1963 and 1964 respectively. This compilation serves as a summary table of the financial status of the World Health Organization for the present period.

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[30] Ibid..

[31] J. Handler, "The Work of the W.H.O.," International Review of Administrative Sciences, XXIX (September, 1963), P. 168.

TABLE 8

SUMMARY TABLE SHOWING TOTAL BUDGET, INCOME ASSESSMENTS, AND EFFECTIVE WORKING BUDGET*
(Expressed in US DOLLARS)

	1962 US $	1963 US $	1964 US $
Total Budget	26,546,940	32,267,570(a)	35,946,540(a)
Deductions	2,398,620	1,383,000	1,256,990
Assessments on Members	24,148,320	30,884,570	34,689,550(c)
Less: Amount of Undistributed Reserve	1,683,140(b)	2,149,570(b)	2,230,540(b)(c)
Assessments on Members for the Effective Working Budget	22,465,180	28,735,000	32,459,010
Add:			
(i) Amount reimbursable from the Special Account for the Expanded Programme of Technical Assistance	642,000	721,000	756,990
(ii) Supplementary Budget Estimates for 1963, being submitted separately		162,000	
(iii) Casual Income	1,756,620	500,000	500,000
	24,863,800	30,118,000	33,716,000

(a) Including unforeseen additional expenses totalling $ 162,000 provided supplementary estimates being submitted separately.

(b) Equalling the assessments on inactive members (Byelorussia SSR, China, and Ukrainian SSR).

(c) These amounts will be subject to adjustments and decision by the 16th W.H.A., if the General Assembly of the U.N. should adopt a scale of assessment for 1963 which differs from that established for the three year period 1962 to 1964, if one or more members should resume active participation in the work of W.H.O., or if the membership of W.H.O. should increase by the time of the 16th W.H.A.

* Official Records of the World Health Organization, Proposed Regular Programme and Budget Estimates for the Financial Year 1 January - 31 December, 1964. No. 121 (Geneva, 1962), P. 11.

Budgetary Problems

The budget, whether in large or small scale organizations, national or international in character, poses the greatest and most detrimental number of impediments and financial crises. The limitations embodying the sources of finance pose numerous budgetary problems and retard the implementation of the set plans and projects. An outstanding and regularly recurring problem, which should be given priority, is posed by the delay in the collection of the assessments levied on the members. The red tape in the collection process of the contributions is attributed to the different legislative systems of the member states. The non-uniform time span consumed by the Legislative Organs and the cumbersomeness of the legislative processes, followed by the governments of the member states, hinder the effectiveness and promptness of the collection process. The inconsistency in prompt remittance and collection of the contributions result in payments in arrears and cause financial complications to the Agency. The equivalent of the deferred payments are withdrawn from the Working Capital Fund to meet the annual financial obligations and are reimbursed upon receipt of the deferrments.

Political controversies and conflicts between member states affect the collection of the assessments. In 1962,

Byelorussia SSR, Hungary, and Ukrainian SSR, were labled as inactive members, as they refused to remit the amounts assessed on them.

The amount of the assessments, collections, and outstanding balance for the financial year 1962, as compared with prior years, appears in Appendix G. The corresponding percentages of the amounts collected for the previous years, 1961 and 1960, stood at 96.1 and 94.00% respectively, as compared to 94.2% in 1962. The assessments for the financial year 1962, amounted to $ 22,465,180, while the amounts collected totalled $ 21,183,091 or 94.2%. The outstanding balance of uncollected amounts from previous years, as at 31 December, 1962, amounted to $ 6,830,538. A sum of $ 936,082 was collected during the financial year 1962, thus leaving an outstanding balance of the previous years to stand at $ 5,884,456.

The decentralized policy practised by the World Health Organization complicates the budgetary process further and itensifies its problems. The difficulty of determining adequate regional budgetary allotments is one of the most serious problems encounted by the Agency. The regions in executing the established plans and projects, are sometimes confronted with additional unforeseen, unaccounted

for expenses, which warrant supplementary appropriations by the World Health Assembly. This consumes time and effort as the authorization for appropriating the supplementary allotments, has to go through the long and cumbersome budget process, of formulation of the supplementary budget estimates till it is submitted to the World Health Assembly for consideration and subsequent authorization.

The financial variations in the regional offices of the World Health Organization are attributed to the peculiarities of the regions. The Regional Office of Africa suffers from economic backwardness and social retardation as compared with a developed and prosperous economic and social systems in the Regional Office of the Americas. The variation in the economic and social systems of the regions create unique and peculiar problems, which necessitate individual financial considerations in respect with the character and conditions of the region. The different economic system and the social customs and norms prevailing, affect the health ethics and standards in each of the regions, which as such require different outlooks and considerations in appropriating the regional allotments.

> Aside from the uneven rates of 'development', the variations in regional expenditures are accounted for by the success or failure in recruiting necessary specialists who may be in short demand and the differences of judgement among national health authorities from one region to another as to what are the most important and pressing needs in the field of Public Health.[32]

Another problem posed and enhanced by the decentralized pattern applied by the Agency, is that of control and review of program planning and budget formulation responsibilities.

> While there are doubtless great advantages in the preparation of programs at the Regional level, the Advisory Committee is not convinced that approval of the regional budget by a regional inter-governmental committee, before the Director-General has formulated his annual program and budget estimates, is entirely satisfactory. Such procedure may give rise to situations in which the Director-General finds it difficult effectively to modify the regional budgets, even though the preparation of the annual budget is his sole responsibility.[33]

The adverse attitude of Headquarters towards regional bodies, caused by the geographical disparity between them, calls for seriousness of effective control and review in

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[32]Robert Berkov, The World Health Organization: A Study in Decentralized International Administration (Geneva: Librairie E. Droz, 1957), P. 97.

[33]Official Records of the General Assembly, 31st Report of the Advisory Committee on Administrative and Budgetary Questions, 9th Session (Geneva, 1954), P. 7.

order to avoid any prejudice in shaping the budget of the regions by misappropriation of the allotments.

Despite the fact that the examination and approval of the budget is the exclusive responsibility of the supreme legislative organ, and although effective scrutiny is accomplished at the regional level, yet numerous obstacles and problems are faced by the control and review process.

The Director-General enjoys the responsibility of presenting the budget and the Health Assembly of its enactment. However, the major portion of responsibility for shaping the program rests at the regional level. The regional office initiates the budget formulation and the regional committee excercises a detailed review of the proposed budget estimates before conveying the final approved draft to Headquarters for further review and approval. However, despite the thorough and careful examination of the programs and budget estimates at the regional level, the instances of reversing the decision or rejection of the initial formulations of the regional office, by the regional committee, are rare. Moreover, the wide variety of the programs and projects executed by the World Health Organization, hinder effective control

and review as the background knowledge and the time needed to examine the budget estimates of each project in detail cannot be achieved.

Another problem confronting the process of control and review arises as a result of the inter and intra physical disparity between regions which necessitate large expenditures for travel and transportation. The need for travelling between and within the regions, as an element of good communication, and for the exchange of experience between the regions add to the problems of controlling and reviewing regional budgets. Inspection reporting, formal visits, and exchange of correspondence between Headquarters and the remote regional offices involve heavy expenses. Planned visits by Headquarters staff to the regions and by regional staff to Headquarters is encouraged, but budgetary limitations exert restraining influence on this favourable attitude to visits.

Shaping regional budgets into their final form depends on the Director-General and the regional machineries. However, although the budget is screened by the regional director and approved by the regional committee, yet the approval of the Director-General is of equal importance. This phase raises controversies and problems during the sessions of the budget hearings.

Effective scrutiny and review is done by the regional committee which consequently raises controversial issues on the initial formulation of the proposal submitted by the regional offices. Moreover, the privilege granted to regional committees to convene away from regional headquarters demands additional expenses.

Another major financial problem is posed by Headquarters and the regional offices concerning the allotments. Problems of allotments are mainly a consequence of under estimation in the amounts appropriated for execution of a certain project. Unforeseen expenditure or underestimation in the cost due to economic fluctuations in the area arise after partial fulfilment of the project. Such a predicament frequently confronts the Agency and supplementary appropriations are the only remedy. However, obtaining authorization for such additional amounts has to go through the hierarchical structure of the intervening responsible bodies, before a resolution is initiated by the Health Assembly authorizing concurrence.

Other than misappropriations of the allotments, the policy calling constantly for economy disrupt the allotments. Thus, if a part of the project can be done from the Headquarters, which will ultimately reduce costs,

such as purchase of supplies or recruitment of the necessary specialists, the Headquarters is empowered to initiate such an action. This action involves red tape before Headquarters releases the allotments and disposes of the finances for a particular project to be resumed.

The role of Headquarters in the process of allotments has been more complicated by the considerations that the regional offices are distant, their responsibilities are vague, and their development is at different rates and patterns.

Finally, the other financial problems of the World Health Organization are common of all international agencies. The scope, extent, and number of projects and plans which can be accomplished by the Agency are far more than its financial potentialities and resources. Despite the constant increase in the budget, yet the width and complexity of the field and competence in which the Agency is entangled draws serious financial limitations and problems. Other than the external financial limitations, internal restrictions on the sources of finance exist. Contributions of a member should not exceed 30% of the total amount of assessments, in order to avoid any leading advantage to that nation or domination of any member state over the other.

The constant pressure for an increase in the funds to the subsidiary units of the Agency, makes it incapable to match the growing economic, social, and health demands of the regions.

The problem of currency management creates another financial obstacle. The contributions of the members are remitted in different currencies, which consequently make a tangible difference during the process of conversion of the currency. Moreover, the effective working budget, is expressed in Dollars at Headquarters, while the allotments to the regions has to be converted to the local currency. The obligations and financial commitments of the World Health Organization at Geneva, are made in Francs although the effective working budget is expressed in Dollars. The financial statements and the payroll in the different areas of operations are made in terms of the local currency. The main three currencies used by the World Health Organization are the Gold Franc, the Swiss Franc, and the Dollar.

> Questions of exchange have a peculiar importance for an international administration. Whereas it is feasible and necessary, to have a fixed currency unit for the income budget of International Agency, the latter is inevitably constrained to make its payments in the different national currencies. Pension annuities have to be paid to retired officials who have gone home to all the ends of earth.[34]

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[34]David Mitrany, "Problems of International Administration," Public Administration Review, XXIII (Spring, 1945), P. 19.

CHAPTER V

THE STAFFING POLICY

The Personnel Rules and Regulations of the World Health Organization portray the dynamic evolution of the concept of personnel administration and the broadened horizons and significance of international personnel administration during the last decades. A description of the Staff Rules and Regulations and the machinery for their enforcement in the Agency will be presented. Further, the principle personnel grievances and the chronic staffing problems encountered will be also tackled.

The World Health Organization, like any other international organization, operates on a world wide basis, and as such has to adopt a set of personnel rules and regulations which should conform with the conditions of service of the staff of the United Nations Organizations, and be commensurate with the personnel policies of the different member states whose nationals are engaged by the Agency. The personnel rules and regulations adopted by the World Health Organization apply for both Headquarters and the regional offices without any discrimination, in order to facilitate the recruitment of a high calibre and efficient staff and maintain their international character.

The presence of a clear set of rules and regulations to govern the staff within the framework of the Agency, give them a sense of security and guidance to the limits of their formal rules of conduct and privileges. Staff Regulations therefore are designated to establish clearly the duties and obligations of the staff, enumerate their rights and privileges and checks on their misconduct. Further, the Staff Regulations provide the machinery for their enforcement and settlement of disputes.

The scope and purpose of the Staff Regulations of the World Health Organization, as stated in the preamble stipulate:

> The Staff Regulations embody the fundamental conditions of service and the basic rights, duties and obligations of the World Health Organization staff. They are the broad principles of personnel policy for the guidance of the Director-General in the staffing and administration of the Secretariat. The Director-General may as Chief Administrative Officer, provide and enforce such Staff Rules consistent with these privileges as he considers necessary.[1]

The First Staff Regulations of the World Health Organization stipulate:

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[1] World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 82.

> All staff members of the Organization are international civil servants. Their responsibilities are not national but exclusively international. By accepting appointment, they pledge themselves to discharge their functions and to regulate their conduct with the interests of the World Health Organization only in view.[2]

The international civil service is relatively a new horizon in Personnel Administration and its status is still unknown, vulnerable and controversial. Thus, it would be wise to explore it further by giving a broad and comprehensive picture of the International Civil Servant, the frame of reference in which he functions and the scope of the responsibilities and limitations imposed upon him.

The international civil servants are scattered over a remarkable variety of institutions which are either universally opened to all states, regionally confined to a particular nation, or merely temporarily set up to meet a particular situation.

> The growth of this group of civil servants and the truely astonishing variety of tasks performed by them represent one of the most significant international developments of modern times. A wide variety of different individuals can be welded into a single Corps

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[2] Ibid.

> of Officials possessing an ability and loyalty comparable with that of almost any national government.[3]

International administration does not differ in kind from national administration as both are forms of Public Administration and the basic personnel principles which are recognized by modern states at the national level are applicable and similar to the personnel standards governing the international civil servants.

> Modern states have learned that certain conditions are necessary to create good national civil service. Recruitment on merit and without discrimination except in so far as it may be thought desirable to secure fair representation for different regions and national groups; protection against outside pressures and patronage; security of tenure for permanent employees; conditions of service comparable to those obtainable in outside employment - these practices make for honest and efficient administration.[4]

The civil servant should not abuse his powers, disclose secrets, or receive instructions from an outside group. Further he should execute the policies irrespective of his personal judgement or criticism. Restriction on his political activity is necessary in order to preserve his impartiality.

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[3] F.R. Scott, "The World's Civil Service," International Concilliation, 496 (January, 1954), PP. 269 - 270.

[4] Ibid., P. 284.

However, broad marked differences exist between the international civil service and its counterpart.

The international civil service deals with treaties and not with laws enacted by a national legislator and it is designed primarily to serve a community of nations and not a particular community. Further, an international civil service is international in character. It is neither 'multi national', that is several national civil service systems co-existing in an international secretariat, nor 'super national', that is authority of a certain national civil service over the others.

> The Staff of an international civil service are drawn from many countries with different backgrounds and outlooks and different methods and traditions of education and administration. Many of them have to work in a foreign language, and most of them have to live outside their own countries.[5]

Each staff of an international civil service, officially owes his allegiance and certain aspects of his life and conduct to the collectivity of the countries composing his organization and not to his national or residential country. While he does not cease to be a citizen of his country with full civil rights and obligations towards both the

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[5] World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 106.

Agency and the host country, he should abstain from any misconduct or abuse of his authority so as not to discredit the prestige of the Organization to which he belongs.

The diversity in the development of the international civil service makes a clear definition of international officials difficult. Suzanne Basdevent, as cited by Young, defined international officials in the following manner:

> International officials are persons who on the basis of an international treaty constituting a particular international community, or by an organ of it, and are under its control to exercise, in a continuous way, functions in the interest of this particular international community, and who are subject to a particular personal status.[6]

Before considering the Rules and Regulations governing the staff of the World Health Organization and the machinery for their enforcement, due regard will be given to the quantitative and qualitative nature of the staff in the Agency, both local and international.

The World Health Organization is served by a number of categories of staff, classified as International, Local

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[6] Tien - Cheng Young, International Civil Service: Principles and Problems (Brussels: International Institute of Administrative Sciences, 1958), P. 15.

and Semi-local, recruited from many countries of different walks of life and consisting broadly of Technical, Administrative and Temporary Offices.

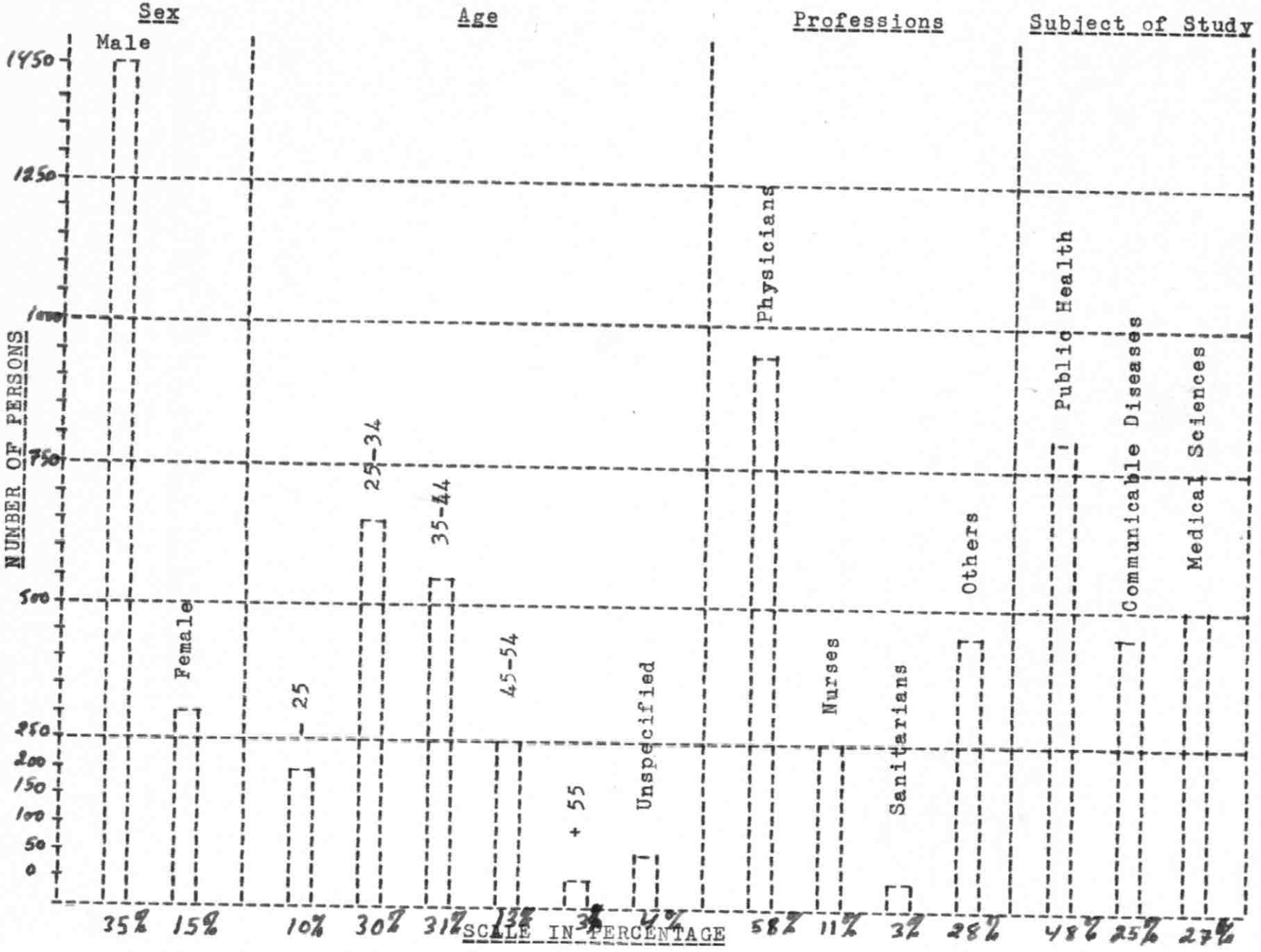
The Technical staff, who are predominantly professional and compose the majority of the Agency's staff due to its highly technical and specialized nature, are distributed on the central and regional levels and consist of technical specialists assigned to render advisory and demonstrative services to the governments on health matters. The technical side comprises Medical and Scientific Officers, Public Health Engineers, Nurses, Health Educators, Veterinarians, Statisticians and Technicians.

An analysis of the technical staff in the World Health Organization, as shown in Chart V, reveals approximately the following relationships regarding their number, sex, age, profession and subject of study:

The aggregate number of staff in the Agency in 1961 totalled 2244. The proportion of the technical professional people in the Agency amounted to 1700 or 75.75 per cent. Out of the 1700 technical staff, 1425 or 85 per cent were male and 275 or 15 per cent were female. The age of the majority of the technical staff is in the vicinity of

CHART V

Sex, Age, Profession and Subject of Study in WHO as of 1961*



*World Health Organization, World Health, XV (July - August, 1962), P. 3.

twenty-five to forty-four, totalling 1200 or 70 per cent. Ten per cent of the staff were under the age of twenty-five and 3 per cent over the age of fifty-five.

975 of the technical people or 58 per cent were physicians and 175 or 11 per cent were nurses. The other 31 per cent of the 550 professionals constituted of 50 or 3 per cent sanitarious and 500 or 28 per cent of other different technical staff.

The distribution of the staff in accordance with the subject of study were as follows: 825 professional or 48 per cent for Public Health, 450 professionals or 27 per cent for Medical Sciences and 425 professionals or 25 per cent for Communicable Diseases.

The administrative officers, at Headquarters and the regional level, consist of Language and Library staff, Information and Liaison Officers, Legal, Financial, Personnel and other administrative officers of various kinds, and the locally recruited general service staff of secretarial, clerical and operative staff of Junior Accountants, Messengers, Duplicating Machine Operators, Telephone Operators, Receptionists, Drivers and Custodial Employees.

A third category of the staff consist of the temporary staff recruited for special purposes. These include short-term specialist consultants either at Headquarters or in the regional offices and the field and the temporary and ad hoc staff engaged for conferences and other special purposes.

The total number of international and local staff of the different categories are distributed at Headquarters, the regional levels and at other organizations, had progressively increased with the increase in the financial status and scope of operation of the Agency.

The total number of staff, as shown in Table 9, has grown from 985 persons in 1951, mostly centrally located, to 2453 in 1962. The World Health Organization since its foundation has witnessed constant increase in its Budget, Membership and hence its staff. The Agency has expanded the scope of its operations and progressed in the fields of health and medical research. "825 projects in 137 countries and territories is the volume of work undertaken by the World Health Organization in 1961"[7] Further, "Working through established institutes all over the world, WHO sponsored hundred and seventy-five projects in 1962."[8]

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[7]World Health Organization, World Health, XV (July - August, 1962), P. 3.

[8]J. Handler, "The Work of the WHO," International Review of Administrative Sciences, XXIX (September, 1963), P. 169.

The greater participation and sponsorship of projects and the increasing decentralization of its activities to distant underdeveloped areas necessitated a constant nourishment of the staff force to attain the prescribed objectives and the highest possible level of health.

TABLE 9

Total Number of International & Local Staff at Headquarters, Regional & Other Offices for the years 1951 - 1962*

YEAR	TOTAL NUMBER
1951	985
1952	1203
1953	1286
1954	1307
1955	1417
1956	1407
1957	1490
1958	1724
1959	1968
1960	2041
1961	2244
1962	2453

* Official Records of the World Health Organization, The Work of WHO: Annual Report of the Director-General to the World Health Assembly and the United Nations (Geneva, 1951 - 1962).

The geographical distribution of staff at the international and local levels for the years 1958 - 1962, as shown in Appendix H, indicates a fairly even distribution of staff between Headquarters, regional and other offices.

In 1962, the total number of international and local recruits, totalled 685 recruits at Headquarters against 683 international and local recruits at the Six Regional Offices and 61 international and local recruits in the area and zone offices. The field staff is constantly growing in number from 629 recruits in 1960 and 779 in 1961 to 905 in 1962, which indicates to the increasing importance the Agency is attributing to the field operations as contrasted with the central and regional operations. Appendix H shows that while the staff figures in 1960 stood at 639 for Headquarters, 622 for the Regional Offices and 629 for the field, which is an even distribution of staff, the staff figures in 1962 show a tangible difference in the distribution of staff between Headquarters and the regional and field staff.

The staffing phase in the World Health Organization warrants careful consideration. This is the backbone of the personnel policy which covers the initial stages of recruitment, examination and selection.

A pre-requisite of a sound administrative set up is the attraction of the greatest number of qualified staff, the selection of the most suitable and the maintenance of high morale among them.

> A basic requirement in building a good staff in an international organization is that every person should realize that he is participating in an endeavour of great importance and usefulness. A second essential is that each employee should see his individual part as necessary to the success of the enterprise. It is upon this foundation that the employees' sense of participation and satisfaction in working for the organization is built. Competitive pay, adequate supplementary benefits, and desirable working conditions are important but they do not in themselves create the kind of enthusiasm which distinguishes routine workers from first rate staff members.[9]

The distinguished former Director-General of the World Health Organization, emphasized the significance of the staffing phase in directing, marshalling and energizing the administrative apparatus of the Agency and maintained that an "Organization is still only an instrument; people, with all their emotional problems and distortions, have to use the instrument sensibly in the service of goals which are sufficiently common to all of them. Loyalty to any one culturally determined way of using the instrument can, and often does, get in the way of such sensible use."[10]

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[9] Donald D. Fowler and Murray D. Bryce, "Building Team Spirit in an International Staff," Personnel Administration, XVI (September, 1953), P. 23.

[10] Walter R. Sharp, Field Administration in the United in the United Nations System (New York: Frederick A. Praeger, 1961), P. 119.

Recruitment

"No element of the career service system is more important than the recruitment policy."[11]

The first step in the recruitment process is to determine the type and quality of the incumbent needed to fill the post and to decide on the prospects and incentives which can be offered to attract the biggest possible number of candidates. This raises the question of long-term versus short-term recruitment policy.

The long-term policy aims at the enrollment of an efficient staff by offering a career prospect to the majority of the recruits. While a short-term policy is based on obtaining a staff to perform a specific job over a fixed period of time which is subject to extension.

A post description providing for minimum qualifications, experience, and the job specifications is prepared for the posts to be filled.

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[11] O. Glenn Stahl, Public Personnel Administration (New York: Harper & Brothers, 1956), P. 59.

The pre-recruitment responsibility lies with the departmental director who is acquainted with the day to day work of his department and the organization and personnel problems encountered.

> The duty then of determining exactly what type of official should be sought lies in the first instance with the director, but is a duty which he should only be asked to carry out after reference to his supervisors; and the duty of his supervisors is to consider not so much an individual appointment by itself as the departments' functions and structure as a whole, and the influence of the individual appointment on that whole both at once and later.[12]

The need to attract competent candidates of different nationalities to maintain geographical distribution among the staff is the formost criterion of the general recruitment policy of the Agency, in order to elicit the consent and satisfaction of the governing Assembly. Rule 310 of the Staff rules of the Agency stipulate:

> The paramount consideration in the selection of staff shall be the competence and integrity of the individual under consideration. For posts in the professional category and above, geographical representation shall also be given full consideration such representation is not a consideration in appointment to posts subject to local recruitment.[13]

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[12] A. Loveday, Reflections on International Administration (Oxford: Clarendon Press, 1956), P. 43.

[13] World Health Organization, Staff Rules (January, 1962), P. 10.

Further, special opportunities should be given to all those whose national educational system, language, or distance from Headquarters stand as an obstacle to their successful competition.

A second basic criterion of the recruitment policy is the age of the recruits. The vacancy notices usually specify an age limit in addition to the minimum qualifications required.

Though experienced persons for senior posts are essential, international organizations primarily dealing with inter - state relations prefer young recruits as the elderly experienced recruits view problems from their prejudiced national angle and rigidly believe that their own way is necessarily the best. The World Health Organization which is technically and scientifically specialized require the greatest proportion of its staff to be professionally experienced recruits. However the risk of engaging some young recruits is minimized by the highly technical nature of its functions as compared with other organizations of political character.

> Normally, candidates under twenty or over sixty years of age shall not be considered for appointment, provided that the minimum age limit for those locally recruited shall be sixteen.[14]

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[14] Ibid., P. 10.

Relatives or persons related by blood or marriage are not recruited if another equally qualified person is available.

The linguistic requirements constitute a third criterion of the pre-recruitment policy. Proficiency in languages is an advantageous tool and an asset to every recruit. However, it is important to ascertain that the linguistic requirements do not constitute an impediment to the selection of a candidate unless it is indispensable to the nature of the post to be filled.

After establishment of the minimum qualifications for the recruits, the search for suitable candidates is the next effective stage of the recruitment policy by testing the market. The incumbents who are qualified to fill a certain position are scattered over the globe in different countries. The sources reverted to in canvassing for qualified candidates to fill a post from outside the service are the following:

(i) Exploratory recruitment missions;

(ii) The announcement of the vacancy on the office notice boards and on those of the various other international organizations;

(iii) Advertisement in some of the leading papers of the countries from which candidates are to be selected in the first instance;

(iv) Inquiries at university appointment boards and similar institutions;

(v) Personal inquiries by members of the staff among friends and committee members competent in the field of work to be covered;

(vi) Informing national governments or official delegates or national committees connected with a specialized Agency;

(vii) A study of the files of persons who have held temporary appointments;

(viii) A study of the files of persons who have applied in the past for some vacancy.[15]

Further, another source for filling vacant posts is by secondment from governments or other international organizations. The formal loan of officials have many advantages. It provides genuine training and enhanced knowledge with the basic methods and problems of international organizations. Staff on Loan to the World Health Organization as at December, 1962 totalled 20 staff members.

"The number of such secondements to any international organization should, however, be proportionally small in order to preserve the international character of the service."[16]

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[15] Ibid., P. 49.

[16] United Nations, Report on Recruitment Methods and Standards for the United Nations and the Specialized Agencies, A Report by International Civil Service Advisory Board (New York, 1950), P. 27.

The number of sources reverted to in filling vacant posts vary from one post to another according to its level of responsibility and difficulty in the hierarchy. Top priority is awarded primarily to promotions of the staff from inside the service. However, if no staff member is suitable, the post is advertised and circulated to all official sources of recruitment for candidates. Personal inquiries of the Agency staff members and the review of the files of temporary appointees are the most frequent and fruitful source of recruitment, as the evaluation and assessment of the qualifications of the candidates is more feasible.

The administrative regulations of the World Health Organization maintain that although the Agency is anxious to maintain geographical distribution of the staff, it should be emphasized that the Agency is under no moral or legal obligation to enroll the candidates recommended by the national governments unless they are the most competent candidates.

Posts requiring recruits of high calibre and qualifications, exploratory recruitment missions substantiated by personal interviews are conducted in addition to the many sources of recruitment.

The recruitment phase ends with the application form, submitted by each of the prospective candidates for consideration. Careful review of the information in the application blanks of the applicant is carried out to determine the merits and capabilities of the applicant, in the light of the minimum qualifications established. Extensive use of investigations about the applicant's past employment and the evaluation of his previous employer is carried out. An extensive use of the interview technique is conducted, if possible, by the personnel and training division and the operating divisions concerned.

The recruitment process at the regional levels of the World Health Organization deviates from the recruitment norms of other international organizations by being partially decentralized to the regional level.

The broad groups of the staff members of the World Health Organization are classified into three broad categories: International recruits, local recruits and Semi local recruits.

"With the exception of WHO, the appointment of all internationally recruited personnel, whether for field offices or for field missions, is subject to approval by Agency Headquarters."[17]

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[17]Sharp, Op.cit., P. 12.

The recruitment of top officials at the regional levels of the World Health Organization is done by the regional committee in consultation with the Executive Board at Headquarters.

The category of top officials, at the regional levels covers the administrative, supervisory and professional or technical, in addition to translators and interpretors if necessary.

The local staff are recruited by the executive head of the offices concerned. This category includes the junior staff of secretaries, typists, clerks, junior accountants, messengers, drivers, machine operators, receptionists and custodial employees. The recruitment of the staff corresponding to the general service category, is restricted to the local area where the Agency activities are located.

Where it is necessary that the staff be recruited from outside the local area and the locality rates are not sufficiently attractive to get the required staff, a permanent non-resident allowance of a flat amount is paid and established at a level sufficiently high to permit recruitment and selection of personnel designated as semi-local recruits.

The procedure and machinery for recruitment of local officials of different categories, varies in accordance with their organizational status and seniority.

The personnel unit of each regional office processes the recruitment of the staff. Vacancies are advertised after establishment of the minimum qualifications and requirements. Careful review of the applications and extensive investigations of the applicants are consequently carried out.

> While regional offices has no machinery of its own for the interviewing of candidates in the region, considerable interviewing is carried on by the staff of the personnel unit, technical officers, area representatives, and project personnel.[18]

Vacancies for senior staff of regional offices are advertised in all Agencies of the United Nations, and applications are referred to the Headquarters. Upon the elapse of thirty days, a list of eligible candidates is compiled and sent to the director of the regional office concerned, who nominates his first choice and two other candidates for the post. Selection is finally made at Headquarters.

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[18] Walter R. Sharp , Field Administration in the United Nations System (New York: Fredrick A. Praeger, 1961), P. 122.

> As regards the recruitment of senior technicians for field project assignments, most of the candidates are in fact provided by the technical division at Headquarters (though occasionally the regional office may also make suggestions) by reason of their cumulative professional contracts, with major recruitment sources (e.g. Public Health Services, Medical and Nursing Schools, and research institutes) - Headquarters thus acts as a clearing-house for candidates and makes the final selection; but it seldom does this without consulting the regional director. The vast majority of the senior professional experts are recruited from outside the region to which they are assigned since it is considered desirable to inject advanced methods and techniques into the area where public health standards are backward. Virtually no field staff, regardless of grade, is appointed against the strong objection of the regional directors concerned; in effect, he has the final word.[19]

The staff rules of the World Health Organization provide for posts which are subject to local recruitment of staff and are designated as special employment conditions.

> All posts in the Secretariat at clerical, custodial, sub-professional and junior administrative levels shall be filled, as far as possible by the recruitment of persons from the local commuting area of each office. The Director-General shall establish conditions of employment for staff engaged from the local area to fill such posts including the fixing of rates of pay and allowances in terms of the best prevailing practices in the local area.[20]

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[19] Ibid., P. 122.

[20] World Health Organization, Staff Rules (January, 1962), P. 41.

A non-residence allowance, fixed by the Director-General is paid to local recruits from outside the local area for such posts. Further the Director-General may grant a bilingual allowance for staff in this category for proficiency in a second language.

Examination

> The problem of evaluating candidates recruited from all the nations of the world is an extensively complex and difficult one. A competative elimination which includes both written parts and other elements is undoubtedly one of the most well defined methods and has many values. At the same time, for certain jobs where written examination is not feasible the principle of open competition can still be maintained.[21]

The written competitive exams although used with marked success by the World Health Organization are restricted particularly for jobs requiring linguistic proficiency such as translators or interpretors, and technical skill ability such as stenographers.

The recent trend in the examining methods is directed towards open competitive examinations. This trend is acquiring more acceptability by the World Health Organization due to its decentralized nature which deems the feasibility of holding written competitive

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[21] United Nations, Report on Recruitment Methods and Standards for the United Nations and the Specialized Agencies, A report by International Civil Service Advisory Board (New York, 1950), P. 27.

examinations not practicable, unless necessary.

The most predominent examination method utilized in staffing the Agency is that of open competitive examination which initially starts by a careful screening and analysis of the personal history data of the candidates. However, if the applicants are for key positions, the evaluation should be based also on the recommendations of the former employers who had the opportunity to observe them discharging their duties.

One of the methods for evaluation of the candidates is the personal interview. The official directly responsible for interviewing the prospective candidates, recommends his first, second, and third choice.

Although Headquarters acts as a clearing house for candidates to posts of high levels at the regional levels and makes the final selection of the senior staff, yet the personnel unit of each regional office processes all staff evaluation by interviews and analysis and sorting of the applications of the candidates before selection or despatch of the applications with a recommendation to Headquarters for selection.

Selection

Staffing the Agency is achieved mainly from two sources: Selection from outside the service by appointment; or selection from inside the service by intra-agency change of the status of the staff through promotion, demotion or reassignment, or by inter-agency transfers from other international organizations. Although priority is given to selection from inside the service, yet it is not a must unless the candidate meets the established minimum qualification to preserve the required standards of efficiency and competence among the staff in the Agency.

The selection process follows the preparation of the list of eligible candidates, compiled from the applicants either from outside or inside the service. The best choices from the list are indicated.

Article 35 of the constitution of the World Health Organization confers upon the Director-General the sole authority for the appointment of the staff subject to provisions of the Staff Regulations.

> The Director-General shall appoint the staff of the Secretariat in accordance with Staff Regulations established by the Health Assembly. The paramount consideration in the employment

> of the staff shall be to assure that the efficiency, integrity and internationally representative character of the Secretariat shall be maintained at the highest level. Due regard shall be paid to the importance of recruiting the staff on as wide a geographical basis as possible.[22]

The staff members of the World Health Organization are at the disposal of the Director-General and are assigned by him to any of the activities or offices of the Agency. The staff are responsible to him in excercising their prescribed functions.

The two basic criteria, primarily considered in the selection of staff, are prescribed as follows in the Staff Regulations of the World Health Organization:

> The paramount consideration in the appointment, transfer or promotion of the staff shall be the necessity of securing the highest standards of efficiency, competence and integrity. Due regard shall be paid to the importance of recruiting and maintaining the staff on as wide a geographical basis as possible.
>
> Selection of staff members shall be without regard to race, creed or sex. So far as is practicable, selection shall be made on a competitive basis.[23]

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[22]World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 466.

[23]World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 84.

In addition, the selection committee or officer, considers other innate characters and qualification standards in the candidates such as; An international outlook, ability to work effectively with persons of any race, religion, colour or cultural background, adaptability to new surroundings and problems, perseverance in carrying out any work load and toleration of any climatic condition.

The appointment policy of the Agency as stipulated in the Staff Rules provide that all staff appointments should be initially on a temporary fixed-term basis of either full-time, part-time or when actually employed basis.

The full-time appointments of more than one year, are subject to a normal probationary period of one year, which may be extended to eighteen months and exceptionally to two years if necessary.

The Director-General is nominated by the Executive Board and appointed by action of the Health Assembly, who in turn appoints the staff of the Secretariat.

Appointment of the Deputy Director-General, Assistant Director-General and Regional Directors shall be for a period not to exceed five years subject to renewal.

> Other staff members shall be granted either permanent or temporary appointments, under such terms and conditions consistent with these regulations as the Director-General may provide.[24]

The selection of the two highest levels of the Administrative Class is done by a Senior Staff Selection Committee which is composed of Three Assistant Directors-General of the Secretariat in addition to the Director of Administrative Management and Personnel who acts as the Chairman of the Committee but is not entitled to a voting power.

Ad hoc committees composed of representatives of the office having the vacant post, another official and a representative of the Personnel Division, select the staff for the lower levels of the Administrative Class. Further the recommendations of the ad hoc committee are subject to review by the Director of Administrative Management and Personnel.

> A distinct doctrine of W.H.O. is that the director of personnel should be given every opportunity to exercise an influence on both policy and selection and indeed should in most cases have the final say.

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[24] Ibid., P. 84.

> The system in force in W.H.O. allows the Head of personnel to exercise great influence, the staff none, and the directors for the higher posts below the directorate level only an extraneous influence. It concentrates power in the heads of the Assistant Directors-General and the head of personnel.[25]

Articles 52 and 53 of the Constitution of the World Health Organization provide for staff appointments at the regional levels, and state:

> The head of the regional office shall be the Regional Director appointed by the Board in agreement with the regional committee. The staff of the regional office shall be appointed in a manner to be determined by agreement between the Director-General and the Regional Director.[26]

The first Director-General of the World Health Organization who advocated for regional decentralization and delegated to the respective regional directors the power of staff selection within the following broad limits maintained that:

> Regional selection committee, set up in each regional office, may make selections for project posts up to and including grade P-4, irrespective of the

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[25]Loveday, Op.cit., PP. 54 - 55.

[26]World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 13.

> origin of the candidates and without confirmation from Headquarters. For regional office posts these committees may select up to and including P-3, except for unit heads at this grade, for which they must obtain approval from Geneva. P-4 posts in regional offices are filled by the Senior Staff Selection Committee at Headquarters. For those posts for which selections are made at the regional level, Headquarters tries to keep the regions supplied with a reservoir of suitable candidates, to be considered along with those available from within the region.[27]

Most of the key posts and top officials, except for recruitment of the highest categories, are selected by a number of selection boards, both at Headquarters and the regions. However, the selection and appointment of the regional staff is controlled by the respective regional directors of the regions concerned, except for the senior posts where final appointment is done by Headquarters in consultation with the respective regional directors.

The personnel units of the regional offices process the staff appointments. Considerable interviewing is conducted by the staff of the personnel unit, technical officers, area representatives, and project personnel.

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[27]Sharp, Op.cit., P. 122.

Concerning the senior staff at the regional levels, the regional directors nominate their first, second and third choice from the list of eligible candidates. Actual appointment is done by Headquarters. The senior technicians for field project assignments are appointed by the technical division at Headquarters, although the regional offices occasionally suggest qualified candidates.

However, although final selection for senior posts is done at Headquarters, the regional directors concerned are constantly consulted on staff-appointments. Further, the Staff Rules governing appointments of personnel in the field projects give the regional directors the prerogative to refuse a nominee or veto an appointment by Headquarters.

The Staff Regulations of the World Health Organization state that: "The Director-General shall establish medical standards which prospective staff members shall normally be required to meet before appointment."[28]

Subsequent to the selection process, the appointee has to undergo a prescribed medical preliminary examination

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[28]World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 85.

by a recognized physician to determine his physical fitness.

The report is forwarded to the Agency's physician for further examination and may be referred to a designated specialist if necessary.

Any offer for appointment or any final appointment is conditioned by a satisfactory report from the Agency's staff physician.

> No appointment shall be confirmed at the completion of the probationary period without a certification by the staff physician that there is no health reservations which would prevent confirmation.[29]

Staff members are re-examined during their employment and inoculated upon the prescription of the staff physician.

A written offer of appointment is sent to the candidate upon selection, signed by, or on behalf of the Director-General.

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[29] World Health Organization, Staff Rules (January, 1962), P. 10.

The offer shall state:

(a) The type of appointment, tenure, probation requirement, title of post, salary and allowances;

(b) The date and place of reporting for duty and the official station;

(c) Transmit a copy of the staff regulations and the staff rules and state that the offer is subject to the current provisions of such regulations and rules, and any subsequent amendments;

(d) Call attention to the medical examination requirements;

(e) State the nature of the duties and obligations which attach to employment in an international organization;

(f) Transmit a notice of acceptance and the oath or declaration of office.[30]

The appointee upon receipt of the appointment documents, signs the notice of acceptance, expressing his approval to the aforementioned conditions. The offer of appointment is confirmed by an appointment notification when the appointee reports to duty and will be modified to reflect any change in status.

The effective date of appointment commences on the date of reporting to duty for local recruits or on the date the appointee enters the travel status if it is required.

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[30] Ibid., P. 11.

The staff are subject to assignment to any activity or office of the Organization by the Director-General and the initial place of appointment does not relieve the staff from any other designated assignment.

Assignment shall be of two types:

(a) Those made under conditions warranting the full establishment of the staff member at his official station, including the movement of his dependants and of household furniture. Such assignments shall be designated Schedule R assignment.

(b) Those made for fixed periods (normally less than five years) under conditions which do not warrant the full establishment of the staff member at his official station. Such assignments shall be designated Schedule S assignments.[31]

In conjunction with the assignment of the place of duty, the place of residence for salary and allowances considerations is determined. In consultation with the appointee, the Organization determines the place of residence of the staff prior to his appointment for purpose of establishing entitlements. The determination of the place of residence is based on the nationality of the staff member where he was residing at the time of appointment.

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[31] Ibid., P. 13.

The Staff Rules provide for reinstatement, at the option of the organization, of staff members other than temporary staff and consultants who are re-employed within a year of their termination. Reinstatement involved restoration of the staff to his former status, charging the period of his absence to his annual leave without pay and reimbursement of the terminal benefits by the staff to the Organization.

Re-employment without any reinstatement, means that the staff will have the same status as any other appointee on initial appointment.

Filling of posts in the World Health Organization from inside the service assumes the following forms:

1- Promotion

2- Re-assignment and change in status

3- Transfer.

"Promotion is as important an aspect of the selection process in personnel administration as original recruitment."[32]

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[32] Stahl, Op.cit., P. 143

The concept of promotion is defined as "the advancement of a staff member to a post of higher grade, either as a result of reclassification of his present post or re-assignment to a difficult post of higher grade."[33]

Two primary considerations, in addition to required minimum qualifications, are accounted for when effecting a promotion policy. These are: factors of competence, integrity and efficiency, and the geographical distribution of the staff.

The promotion standards as stipulated in the Staff Regulations of the World Health Organization, state:

> Without prejudice to the inflow of fresh talent by the various levels, vacancies shall be filled by promotion of persons already in the service of the Organization in preference to persons from outside. This preference shall also be applied, on a reciprocal basis, to the United Nations and Specialized Agencies brought into relationship with the United Nations.[34]

The principles on which promotion is based involve ascent within a grade by salary increments, regrading to thenext higher grade and reclassification to a senior post of a higher grade.

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[33]World Health Organization, Staff Rules (January, 1962), P. 15.

[34]World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 84.

Upon the completion of a unit service and certification by the supervisor of a satisfactory performance of a staff member, he is entitled to a one step increase within a grade provided he has not attained the top of his grade and his appointment has been confirmed.

> All satisfactory service time, except continuous periods of special leave and leave without pay of more than 30 days shall be credited towards the service requirements which are:
>
> (a) One year of full-time service in levels P-1 through P-6/D1 step IV of the schedule;
>
> (b) Two years of full-time service in levels P-6/D1 step IV through D2 step III of the schedule;
>
> (c) Such periods of full time service as the Director-General may establish for posts subject to local recruitment;
>
> (d) The equivalent amount of part-time service.
>
> Service time shall date from the latest of the following actions:
>
> (a) Entrance on duty;
>
> (b) The last within-grade increase;
>
> (c) A promotion to a higher grade.[35]

The performance of staff members which is exceptionally beyond that of a normal qualified staff, may be granted a

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[35]World Health Organization, Staff Rules (January, 1962), P. 15.

meritorious one, or exceptionally two, extra steps in the scale of his salary. The meritorious within-grade increment will not effect the normal within-grade increase in the grade of the staff.

Promotion from one grade to another does not occur at the attainment of the top of his grade nor depends on seniority considerations, but simply involves upgrading to a post of higher calibre and levels of difficulty with enhanced duties and responsibilities.

Promotion to senior posts is rigidly conditioned by the basic requirements for senior qualifications which the incumbent must possess. This type of promotion infers re-adjustment of the post and grade of the staff member to conform with his qualifications and abilities.

> Posts below the levels of Director, other than those of a temporary nature, which become vacant shall normally be notified to the staff if they represent a promotional opportunity for any staff, and selectionfor such posts shall normally be on a competitive basis. These requirements shall not apply to any post which it is in the interest of the Organization to fill by re-assignment of a staff member without promotion.[36]

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[36] Ibid., P. 15.

The re-assignment process refers to the official movement of staff along the levels of the hierarchy from his post to a more or less responsible post and grade.

The movement of the staff may involve a change in title, grade, salary, station or a combination of these changes. Further, a staff is re-assigned if it is in the interest of the Agency. The Agency considers any request for re-assignment by a staff in his own interest.

> So far as practicable, vacancies in posts in the professional category and above shall be filled by re-assignment of staff members between the different activities and offices of the Organization in the interest of developing a versatile career staff. In accepting appointment, a staff member accepts the applicability of this policy to himself.[37]

Reduction in grade of a staff member occurs by reclassification of his present post to another post of lower duties and grade, due to the following reasons:

(a) upon the request of the staff for personal reasons;

(b) unsatisfactory performance of the duties and responsibilities of the post;

(c) on grounds of redundancy of the post as an alternative to termination.

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[37] Ibid., P. 16.

The reduction in the grade of a staff on grounds of unsatisfactory performance follows receipt of a justification by the staff, within eight days, to the notification of the proposed action.

Changes in the official status of staff members to reflect his personal or employment situation involves the following actions:

(a) Change in type of appointment;

(b) Extension of appointment;

(c) Change of title;

(d) Change of name;

(e) Adjustment of salary (after change in salary schedule);

(f) Leave without pay and special leave (in excess of 30 days);

(g) Return to duty from leave without pay or special leave;

(h) Change of official station.[38]

The staff receives a written notification in the above effect and the notice extends for a period of not less than thirty days. The appointment notification serves as an amending document to the contract of employment specifying the change of status.

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[38] Ibid., P. 16.

> The interchange of staff between the World Health Organization and its sister specialized agencies is facilitated in order to obtain the maximum benefit from their services and to obtain the eventual development of a single unified international civil service. The principle of transfer by promotion across the Agency lines is a highly significant one and should be re-affirmed. Efforts to give it practical effect should be redoubled.[39]

The Staff Rules of the Agency establish a set of standards to streamline the transfer policy of staff from all United Nations Organizations:

(a) May be appointed at an advanced step in the grade of the post to which he is being assigned if necessary to maintain his existing salary level;

(b) Shall be credited on transfer with accumulated annual leave and earned services time towards the next within-grade increase, home leave and repatriation grant;

(c) Shall transfer his pension fund credit if a participant in the United Nations Joint Pension Fund;

(d) Shall serve the same probationary period as any other staff member but upon confirmation shall have the same seniority status as if all prior uninterrupted service with United Nations Organizations had been with the World Health Organization.[40]

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[39] United Nations, Report on Recruitment Methods and Standards for the United Nations and the Specialized Agencies, A Report by International Civil Service Board (New York, 1950), P. 34.

[40] World Health Organization, Staff Rules (January, 1962), P. 16.

Despite the resemblence in the international nature of the specialized agencies, the different personnel policies stand as an impediment to the effective transfer of staff. Transfers are often in the nature of terminations and re-appointment rather than transfer in the real sense and if transfer is to play an effective role, the different staff regulations, conditions of employment and pension provisions should be reconciled and the differences minimized.

> The policy of periodically transferring members of the Secretariat from one WHO office to another, commonly referred to as "rotation", though not yet fully developed, has been successfully applied in limited fields, and it is the established policy periodically to "rotate" staff in administrative and financial posts. Medical and scientific officers have also been "rotated", although less systematically.[41]

The uniformity in personnel rules between the Headquarters and the regions facilitates the transfer of personnel and their interchangeability. Increasing efforts are made to transfer staff between regions and Headquarters, but it appears that it is easier to arrange transfer of regional office personnel to Headquarters than to induce Headquarters staff to be transferred.

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[41] World Health Organization, The First Ten Years of The World Health Organization (Geneva, 1958), P. 110.

Further, transfer of a staff unwillingly is detrimental and disruptive of morale.

The effectiveness of transfer is limited to the professional staff. The tours of the fixed-term administrative and professional staff of the World Health Organization at the regional levels average three to four years, while permanent appointees, are usually assigned for indefinite periods.

> The interchange of technical personnel among WHO regional offices has been vigorously encouraged during recent years but with only modest success. Apart from language and cultural factors, it has not been easy to persuade able specialists to shift their base to another region on account of health or family considerations. Further, the decentralized system of regional appointments, which in effect gives a regional director the right to veto a candidate from another region when proposed by Headquarters, does not always facilitate inter-regional transfers.[42]

The increasing efforts to encourage the staff rotational scheme, the enlargement in the work loads of the regional offices and the growing importance in the field program activities, led Headquarters to devise a team of well trained staff, designated as 'floaters', for administrative, budget, personnel, and supply functions.

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[42] Sharp, Op.cit., P. 159.

> Assignment at a given regional office is limited to four to six years for such officers, following which they normally are sent back to Geneva for "refresher" experience. This system involves periodic shifts of administrative personnel from one regional office to another. During pressure periods, or during absence of administrative officers on home leave, temporary assistance can be provided by drawing upon experienced rotational staff from Headquarters.[43]

Probation

Probation as a step in the selection process is defined as follows:

"Probation is the policy of considering no appointment final until the appointee has demonstrated his capacity in his work."[44]

A period of probation prior to appointment is indispensable and should be treated seriously to evade the the consequential risks of inappropriate selection.

> Since persons of many different nationalities must be recruited and must eventually prove suitable for work in a strange country under strange conditions, a period of probationary service is required and considered as part of the process of selecting permanent staff.[45]

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[43] Ibid., P. 159.

[44] Stahl, Op.cit., p. 139.

[45] United Nations, Report on Recruitment Methods and Standards for the United Nations and the Specialized Agencies, A Report by International Civil Service Advisory Board (New York, 1950), P. 33.

The minimum probationary period for any full-time appointment is one year and may be extended to eighteen months, or two years in exceptional circumstances if the need arises. A satisfactory service of a staff in the Organization prior to full-time appointment may be credited towards completion of the probation.

A periodic evaluation report concerning the performance of the staff member is prepared by the direct supervisor before the expiry of the normal probationary period. On the basis of the periodic evaluation report and the certificate of medical fitness, a decision on one of the following alternatives is transmitted to the staff:

(a) Appointment is confirmed;

(b) Probationary period is extended for a specific period;

(c) Appointment is not confirmed and is to be terminated.

In the case of either (b) or (c), the staff member shall be notified of the reasons. If the probation is extended, a further report and decision is required before the expiry of this additional period.[46]

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[46] World Health Organization, Staff Rules (January, 1962), P. 14.

The analysis of the staff standards shall entail the position classification scheme and the grading pattern adopted by the World Health Organization.

The staffing remuneration policy refers to the concept of pay and the determination of the salary level prevailing in the Agency. The related allowances and expenditure emoluments to the staff, the fringe benefits and the social security plan for the protection of the staff will be considered.

Position Classification Plan

The position classification scheme aims at systematic organization of posts into groups or classes, in accordance with the nature of their duties and responsibilities.

The Staff Rules of the World Health Organization provides for a Classification Plan and state:

> The Director-General shall establish a plan for the classification of all posts in the Organization according to the type and levels of the duties and responsibilities of the posts and the qualifications required of the staff who occupy them. This plan shall include standards by which individual posts are to be classified."[47]

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[47] Ibid., P. 2.

The classification plan covers all posts in the Organization except posts of temporary staff and consultants, and assigns to each post an official title and pay grade.

The many and different posts in the Agency are classified into four broad categories:

(a) Director and Principal Officers: Top policy-making and administrative posts.

(b) Substantive Service: Professional, general administrative and information officers, language and librarian personnel.

(c) Special Service: Special Administrative and executive personnel such as accountants, printers, etc.

(d) General Service: General clerical and secretarial staff, including manual and custodial staff.[48]

The total number of regular international and local posts in the World Health Organization in 1962 totalled 1724 while the corresponding total number of staff members in 1962 as shown in Table 10 totalled 2453. Hereunder is a summary Table showing the total number of international and local posts in the Agency for the years 1961 - 1964,

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[48] United Nations, Report on Recruitment Methods and Standards for the United Nations and the Specialized Agencies, A Report by International Civil Service Advisory Board (New York: 1950), P. 37.

classified under the regular and other programmes in which the Agency participates.

TABLE 10

TOTAL NUMBER OF INTERNATIONAL AND LOCAL POSTS

FOR THE YEARS 1961 - 1964*

YEAR	Regular	Malaria Eradication Special Account (Regular)	Expanding Programme of Technical Assistance	Other Extra Budgetary Funds
1961	1646	253	470	1000
1962	1724	245	513	1075
1963	1819	275	500	1089
1964	2139	-	451	1092

*Official Records of the World Health Organization, Proposed Regular Programme and Budget Estimates for the Financial Year 1 January - 31 December 1964, No. 121 (Geneva, 1962), P. XXV.

For further reference, Appendix I gives a detailed and tabulated presentation, of the number of International and Local posts by grade and salary levels, for the years 1962 - 1964.

A review of a classification and grade of a post may be re-examined at any time by the Staff Management Unit upon the request of the incumbent or his supervisor.

Salary Administration & Grading Pattern

The concept of salary as defined in the Staff Rules of the World Health Organization means "the remuneration received by the staff members by application of a salary schedule or an extension of such a schedule including an extra compensation for Languages proficiency."[49]

The salaries of the professional staff of the World Health Organization is paid on the basis of an established salary scale in accordance with the grade of the position and extending over a number of steps. Upon appointment of a staff member, the salary is established at step one of the grade of the post to which the incumbent is assigned. In exceptional cases, the salary may be established at an advanced step in the grade in order to maintain the former income level of the staff. The salaries are effected by a series of related allowances depending upon the place of assignment, family status, proficiency in additional language and other related allowances and entitlements which will be discussed later.

The salary of the Director-General is determined by the World Health Assembly and the salaries of top officials

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[49]World Health Organization, Staff Rules (January, 1962), P. 3.

in the Directorate level are determined in the following manner; "The salaries for the Deputy Director-General, Assistant Directors-General and Regional Directors shall be determined by the World Health Assembly on the recommendation of the Director-General and with the advice of the Executive Board."[50]

The salary scale of the professional category consist of eight grade levels, extending over a number of steps. The grading pattern starts in an ascending order with a P1 to UG. The symbols P, D and UG stand for Professional, Directors and Under-Secretary General . Assignment of a grade to a staff member depends on the post classification and grading, and advancement in the steps of the grade depends on the periodic performance of the incumbent.

The salary scale of international staff in the World Health Organization which appears in Table 11 and Appendix I and expressed in U.S. Dollars, is designed to remunerate the staff members according to their grades and their advancement by steps.

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[50] World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 84.

TABLE 11

SALARY SCALE

FOR POSTS IN THE PROFESSIONAL CATEGORY AND ABOVE

(Expressed in U.S. DOLLARS)

GRADE	STEP I	STEP II	STEP III	STEP IV	STEP V	STEP VI	STEP VII	STEP VIII	STEP IX	STEP X	STEP XI	STEP XII
P1	4800	5000	5190	5380	5560	5750	5940	6130	6310			
P2	6130	6310	6500	6690	6880	7060	7250	7460	7670	7880		
P3	7460	7670	7880	8090	8300	8510	8720	8930	9180	9420	9640	9870
P4	8930	9180	9420	9640	9870	10130	10390	10650	10910	11170	11420	
P5	10650	10910	11170	11420	11660	11950	12240	12520	12810	13100		
P6/D1	12080	12500	12920	13340	13760	14140	14530					
D2	14530	15020	15520									

*World Health Organization, Staff Rules, (January, 1962), P. 4.

The base salaries of staff in the professional category and above are subject to a post adjustment in accordance with a salary adjustment scale shown hereunder in Table 12, to reflect differences in the cost of living and different duty stations. "For each five per cent by which the cost of living in Geneva or at any other official station, exceeds the base level, the staff of the professional category and above at that official station shall be paid a post adjustment."[51]

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[51] Ibid., P. 5.

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P3	7460	7670	7880	8090	8300	8510	8720	8930	9180	9420	9640	9870
P4	8930	9180	9420	9640	9870	10130	10390	10650	10910	11170	11420	
P5	10650	10910	11170	11420	11660	11950	12240	12520	12810	13100		
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[51] Ibid., P. 5.

TABLE 12

POST ADJUSTMENT SCALE FOR THE PROFESSIONAL CATEGORY AND ABOVE*

GRADE	STEP I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII
P1	216	228	240	252	252	252	264	276	288			
P2	276	288	300	312	312	312	324	336	348	360	432	1144
P3	336	348	360	372	372	373	384	396	408	420	492	
P4	396	408	420	432	432	432	444	456	468	480		
P5	468	480	492	504	504	504	516	528	540	552		
P6/D1	504	516	528	540	552	564	576					
D2	576	600	624									
UG	720											

*World Health Organization, Staff Rules (January, 1962), P. 5.

Staff who are entitled to post adjustments but are without dependants are eligible for two-thirds of the adjustment.

The Salary Schedule and Post Adjustment Scale of the World Health Organization have been amended many times since the establishment of the Organization. The change is attributed to two main factors: the cost of living index and the fluctuation in the purchasing power of the currency.

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P4	396	408	420	432	432	432	444	456	468	480		
P5	468	480	492	504	504	504	516	528	540	552		
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The Salary Schedule and Post Adjustment Scale of the World Health Organization have been amended many times since the establishment of the Organization. The change is attributed to two main factors: the cost of living index and the fluctuation in the purchasing power of the currency.

The Staff Rules stipulates in this connection:

> Assessment of the cost of living at each official station in relation to the base level and measurement of the movement of the cost of living at each station shall be made on the basis of statistical procedures agreed among the International organization concerned.
>
> The Director-General may apply temporary per cent differentials to the salaries of staff members in posts in the professional category and above when he determines that the purchasing power of these salaries is materially effected by re-evaluation of the currency of the country in which they are stationed.[52]

The salary of a staff who is promoted to a higher grade, will be established at step one in the new grade provided that it is not less than his present salary and the increase which would have resulted from the within-grade increase in his old grade. Further, upon rotation of a staff to a higher post formerly held by him, his salary should not exceed that which he would have attained, had he remained in the formerly held post.

Determination of the salary upon reduction in grade of a staff depends upon the reasons for demotion. If the reduction in the grade is due to reduction in force, the salary of the staff will be protected by establishing it at the step in the lower grade corresponding to his current

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[52] Ibid., P. 5.

salary or at the nearest step if there is no corresponding equivalent. On the other hand, if the reduction in grade is due to unsatisfactory performance, the salary will be established at the first step of the reduced grade.

A staff member who is temporarily replacing an incumbent of a higher graded post will be entitled to extra pay upon the elapse of four consecutive months of service. The extra pay represents the difference between the current salary of the staff and the salary he would have received if promoted to the higher graded post.

The effective date of change in salary due to change in status by a promotion to a higher grade, or by within-grade increase, or by reduction in grade shall be the first of the month following completion of the required notice period.

The currency unit and the rate of exchange for salaries to the staff are determined by the Director-General within the legitimate interests of the staff.

The staff salaries are subject to the following deductions at the source:

(a) For the staff member's contributions to the Staff Pension Fund and for Health Insurance;

(b) For indebtidness to the Organization;

(c) As otherwise authorized by the staff member and agreed by the Organization.[53]

Advancement on salaries to staff members is permissable in emergencies subject to approval of a competent authority, and if it falls during an authorized execused leave or official duty.

All claims in respect of allowances or entitlements are repudiated if submitted after the elapse of a period of twelve months.

Salaries of posts at the local level are determined in accordance with the nature and status of the posts.

The salaries of top locally recruited officials provided by Headquarters at Geneva, to the respective field offices, are determined in accordance with a salary scale, expressed in Swiss Francs, which appears in Appendix I. The grading pattern consists of Seven Levels, starting with G-1 to G-7, and each grade extends into eleven steps.

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[53] Ibid., P. 9.

The grade symbol stands for Geneva in order to differentiate it from the other international professional staff designated by symbol P.

"The salaries of locally recruited general service staff are based on the best prevailing local rates."[54]

Related Allowances and Entitlements

The staff are entitled to salary allowances and emoluments in accordance with a set of prescribed rules and provisions.

The Staff Rules provide for a Bilingual Allowance, granted by the Director-General, for proficiency of a staff member in an additional language which is useful to the Organization.

Another related pensionable remuneration allowance, established by the Staff Rules, is known as the Non-Residence Allowance. "Any such staff member recruited outside the local area and outside the country of the official station may be paid an annual Non-Residence Allowance in an amount to be fixed by the Director-General for each area."[55]

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[54] World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 109.

[55] Ibid., P. 41.

The Assignment Allowance is established for all staff members except those on temporary appointments and consultants, who are expetriated to the official station for a fixed period, normally not less than five years and designated by the Agency as Schedule S Assignments, provided that the official station is other than their permanent place of residence. The Assignment Allowance is designed to compensate the staff for the change in the environment and living conditions, and to elicit their willing and favourable consent to this change.

The allowance rate varies by grade and differs between those with and without dependants. The Director-General will establish a table of rates to give effect to the above emolument. Normal ceasure of the Assignment Allowance occurs upon the elapse of five consecutive years of service by a staff at any one duty station.

Another staff emolument is the Dependant's Allowance. The Staff Rules explicitly determines the following as entitled dependants.

> A spouse whose occupational earnings do not exceed the lowest entrance level of the organizations local salary scale for the area in which the spouse is employed, or in the case of a staff member at Grade P1 or above, if the earnings do not exceed US$ 1,850 per annum if this be more than the lowest entrance salary of the local scale, provided

> That if both husband and wife are staff members of the United Nations Organizations neither may be recognized as a dependant.[56]

The Dependants Allowance for children is applicable to those up to the age of eighteen and up to twenty-one if they are in full attendance at a school or university. It is applicable further to children who are physically or mentally incapacitated. Children of parents who are both staff members in United Nations Organizations and entitled to Dependants Allowances, are recognized as dependant of one of the parents who is holding the higher post.

The claim for Dependants Allowances for a parent, brother or sister who are within the above mentioned age limits is applicable only to one of the dependants provided that the staff member contributes not less than the total amount of the support or twice the amount claimed.

Dependants Allowances can be claimed only by full time staff of professional grade and above except temporary staff and consultants.

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[56] World Health Organization, Staff Rules (January, 1962), P. 3.

The rate and provisions of Dependants Allowance is as follows:

(a) US$ 400 per annum for a spouse;

(b) US$ 300 per annum for a child;

(c) US$ 200 per annum for a parent, or a brother or sister.

Provided that a staff member having an entitlement under (a) or (b) may not claim under (c), and provided further that an allowance payable under (b) shall be reduced by the amount of any benefit which the staff member or his (her) spouse may receive, by reason of such child, from public sources by way of social security payments.[57]

A fifth staff entitlement is the Education Grant to children of internationally recruited staff who are on assignment outside his place of residence. The Education Allowance is payable subject to the following provisions:

The amount of the grant for full time attendance at an institution outside the duty station shall be seventy-five per cent of the cost of attendance and a maximum of $ 600 for boarding if provided by the institutions, or $ 400 in addition to seventy-five per cent of the cost of attendance up to a maximum grant of $ 600 per annum, if the institution does not provide boarding facilities.

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[57] Ibid., P. 5.

If the educational institution is available at the area of duty station, the staff is entitled only to 75 per cent of the cost of full time attendance, up to a maximum of $ 600 per annum.

Fringe Benefits

In addition to the related allowances attached to the basic salary of staff members, a number of benefits accrue during the service, upon completion of the service duty or upon termination.

> A staff member who leaves the Organization on completion of, or while holding a fixed term appointment of at least one year but less than five years and on completion of at least a year of service, shall be paid a service benefit equal to four per cent of salary for any period of service in his recognized country of residence and eight per cent of salary for any period of expatriated service.[58]

Conversion of the fixed-term appointment into a career service appointment, or its extension into a five years duration cancels the service benefit. Further any fixed term appointment subsequent to a five years appointment terminates any entitlement for service benefits.

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[58] Ibid., P. 7.

Staff members holding the following appointment conditions, are entitled to a repatriation grant benefit upon leaving the Agency for reasons other than misconduct:

a) A five years fixed term or career service provided that he has completed two or more consecutive years of service;

b) A fixed term appointment of less than five years provided that he has completed five consecutive years subsequent to January 1958, and at an official station outside his own country.

The following Table gives the rates on which the grant is computed provided that it does not exceed the sum of US$ 2,500 for a staff without dependants and US$ 5,000 with dependants.

TABLE 13

SCALE FOR REPATRIATION GRANT WITH AND WITHOUT DEPENDANTS*

Years of Service	Weeks of Salary	
	Without Dependants	With Dependants
2	4	8
3	5	10
4	6	12
5	7	14
6	8	16
7	9	18
8	10	20
9	11	22
10	12	24
11	13	26
12 or more	14	28

*World Health Organization, Staff Rules (January, 1962), P. 8.

Staff members, upon completion of service or upon termination, are entitled to terminal payment benefits. Payments in lieu of notice and accumulated annual leave, indemnities, service benefits, and repatriation grant.

"Terminal payments shall be computed at the salary rate to which the staff member is entitled on the date of termination."[59]

The payments for any indemnity and repatriation grant are computed on pro rata basis on the salary level plus any non-residence allowance. Payments for accumulated annual leave are computed at the rate of 1/260 of the annual salary.

The staff of the World Health Organization, as any other staff of international organizations, enjoy eight days of official holidays per annum. The dates are fixed in accordance with the most popular and commonly observed holidays in each of the respective localities.

Staff members are compensated by a compensatory leave when authorized to work overtime. Staff in professional

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[59] Ibid., P. 9.

status are not given compensatory leave while local staff may be given compensatory leave or monetary reward.

Full time staff except temporary appointees, consultants and those engaged on a "When-actually-employed" basis are entitled to annual leave. The rate on which annual leave is determined corresponds to two and one-half working days for each calendar month, and is taken by staff in one unit day or half days. The annual leave is not accounted for during periods of leave without pay, special leave or maternity leave.

Advanced annual leave may be authorized in exceptional cases and not more than fifteen days may be carried over to the next year. Periods of sickness during the annual leave may be credited to sick leave upon presentation of a valid medical certificate. Further, unexhausted days of annual leave, up to sixty days may be paid to a staff upon leaving the Organization. Advanced annual leave should be refunded by the staff upon leaving of the Agency. In case of death, unused annual leave is paid to the legal heirs while advanced annual leave taken by the deceased will not be deducted.

Home leave entitlements are applicable to full time staff excluding temporary appointees, consultants and local recruits, whose official duty station is not their country of residence. Every two consecutive years of service, the staff is entitled to a home leave provided that he will resume service for at least six months from the day of his return or six months from the date of eligibility whichever is later.

> Home leave entitlements shall consist of travel time without charge to annual leave and return transportation at the Organization's expense for the staff member and eligible dependants, between the official station and the place of residence in the home country, or any other place in the home country which does not involve greater expense to the Organization.[60]

The special leave is granted mainly for purposes of research and further study or any valid reason, either with full, partial or without pay and should not exceed one year duration or until all accrued leave is exhausted.

The leave without pay is given for purposes of physical unfitness or as an advancement on annual leave.

> Periods of leave without pay in excess of thirty days shall not be credited for purposes of:

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[60] Ibid., P. 20.

(a) Annual leave accrual;

(b) Service credit towards within-grade increase and completion of probation;

(c) Service credit for repatriation grant and termination indemnities;

(d) Service credit for home leave.[61]

The leaves for military service required by the governments may be granted to staff members, other than those with temporary appointments and consultants, for a period of one year subject to renewal if requested. The leave is credited to the annual leave accrued and thereafter to leave without pay.

Staff members who are incapacitated by injury or illness from performing their duties or who are suffering from ill health are entitled to a sick leave.

A staff member holding an appointment of one year or more is entitled to a sick leave of six months with pay during any period of twelve consecutive months or in connection with an illness provided that the aggregate shall not exceed nine months in any four years period. Appointees for a period of less than one year are entitled

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[61] Ibid., P. 21.

to a sick leave proportionate to the period spent in service at the rate of thirty full and half pay working days.

Absence from service of more than three days should be substantiated by a medical certificate. However, not more than seven intermittant and medically uncertified days of sick leave may be granted during twelve consecutive months.

"Full time staff members appointed for periods of one year or more who will have completed at least one year's continuous service at the anticipated date of confinement shall be entitled to maternity leave."[62]

The Maternity leave commences upon presentation of an authenticated medical certificate indicating that confinement will take place within six weeks, and reporting for duty will not be acceptable before six weeks after the delivery. The period of twelve weeks absence will be at full pay.

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[62] Ibid., P. 23.

The Organization will undertake to shoulder the travel expenses of staff, subject to the following provisions:

(a) Upon appointment and on subsequent change of official duty station;

(b) Upon the taking of leave at home when authorized, and

(c) Upon separation from the service.[63]

The Agency shoulders all authorized travel expenses incurred by a staff in respect with his official duty; all expenses arising from the death of any official in a country other than his place of residence, and expenses authorized by the Director-General for ill or accidented staff who need special treatment facilities determined by the Agency physician and not available at the official station or the nearest place to it.

The dependants of staff members except for temporary appointees and consultants, are entitled to the travel and transportation benefits upon assignment of the staff to his official station for more than one year, change of official station, home leave and termination. Further, in case of death at the official station, accident or illness which

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[63] World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 85.

requires special treatment facilities and for each child entitled to the education grant from the place of study to the duty station, the travel and transportation expenses incurred in the above respect by the dependants will be shouldered by the Agency.

The dependants entitled for travel and transportation benefits are restricted to the following:

(a) A wife or a husband;

(b) Children who are up to the age of eighteen; or up to the age of twenty-one if at university; or children who are physically or mentally incapacitated;

"(c) A child for whom travel expenses have previously been paid by the Organization, to the extent of the final one-way passage to join the staff member at the official station or to return to the home country within one year after ceasing to qualify as a dependant."[64]

However, the organization is not held responsible for any travel risks of dependants.

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[64]World Health Organization, Staff Rules (January, 1962), P. 27.

Staff members and dependants are entitled to a travel allowance per day to be established by the Director-General, when they are in authorized travel status.

> On appointment for a year or more, or change of official station, involving authorized travel, installation per diem shall be paid to the staff member for himself and eligible dependants, up to a total of four, normally for the following periods:
>
> (a) To a staff member unaccompanied by dependants - 15 days.
>
> (b) To a staff member accompanied by dependants - 30 days.
>
> (c) To dependants - 30 days.[65]

Installation allowances paid for staff or dependants are recoverable upon resignation or separation of the staff from the Organization within a period of six months from the date of appointment.

The route and mean of transportation involving travel expenses are determined by the Organization. The staff member has the option to choose a different route and mean provided that the extra costs are shouldered by him.

The transportation costs of personal effects of a staff member who is in an authorized travel status, are

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[65] Ibid., P. 27.

shouldered by the Agency within limits set by the Director-General. A staff is entitled for reimbursement of the cost of moving his household effects to his duty station, when his appointment is not less than two years and on subsequent change of his duty station, except those on Schedule S Assignment, and upon termination of his appointment provided that the removal entitlement is stipulated for in his appointment documents. Indemnity for loss of personal property of the staff, as a result of conditions of service, may be authorized by the Director-General provided that precautions were taken to safeguard and insure the property and the claim for indemnification is restricted to the basic living items. The maximum amount of the indemnity in the above respect may not exceed in aggregate the sum of $ 1,000.

Social Security Measures

The World Health Organization in safeguarding the physical conditions and financial status of its staff provides for a social security scheme. The Staff Regulations stipulate in this respect:

> The Director-General shall establish a scheme of social security for the staff, including provisions for health protection, sick leave and maternity leave, and reasonable compensation in the event of illness, accident or death attributable to the performance of official duties on behalf of the Organization.[66]

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[66] World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 85.

Further, staff members are entitled to participate in the United Nations Joint Staff Pension Fund as a protective measure to complement the social security scheme designed by the Agency.

Full-time staff members and their dependants are entitled to participate in the Staff Health Insurance plan of the Agency by payment of contributions. The rules of the plan are established by the Director-General in consultation with the respective staff.

The plan insures against the risks of accidents and illness to the extent of the rules prescribed in the Organization's Accident and Illness Insurance Policy.

Staff members engaged on "When actually employed" basis, for one year or more, have the option of joining the plan against payment of contributions established by the Director-General.

Non-participants in the Staff Health Insurance Plan enjoy the benefits of the hospitalization plan by contributing towards its cost. The plan insures against medical and hospital expenses, and indemnifies against death or disability in accordance with the Organization's Accident and Illness Insurance Policy.

> Participants in the Organization's Staff Health Insurance in any region, any regional office, or at Headquarters may, by decision of the majority of those voting in a referendum, participate in a plan of dental benefits in accordance with rules established by the Director-General in consultation with the interested staff.[67]

Illness, accidents or death attributable to the performance of the duties of a staff member are recompensated in accordance with rules established by the Director-General. All benefits payable under the provisions of the Staff Pension Fund, the Organization's Accident and Illness Insurance Policy or the Staff Health Insurance Plan are accounted for when indemnifying a staff member.

Upon the death of a staff member engaged on a five year fixed-term or career service appointment but is not entitled to indemnity payments under the Organization's Accident and Illness Insurance Policy, compensation to the legal heirs is granted in accordance with the following indemnity scale.

TABLE 14

INDEMNITY SCALE UPON DEATH TO LEGAL HEIRS*

YEARS OF SERVICE	MONTHS OF SALARY
3 or less	3
5	4
7	5
9 or more	6

*World Health Organization, Staff Rules (January, 1962), P. 25.

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[67]World Health Organization, Staff Rules (January, 1962), P. 24.

Full-time staff members of international organizations are entitled to join the United Nations Joint Staff Pension Fund as "participants" or "associate participants".

Conditions for joining the Fund as participants is exclusively restricted to full-time staff, subject to the following terms of appointment:

> (a) His initial appointment is a permanent appointment or an appointment certified by the member Organization to lead normally to a permanent appointment; or
>
> (b) His initial appointment is for five years or more; or
>
> (c) Having been initially appointed for less than five years, he subsequently receives;
>
> (i) A permanent appointment, or an appointment certified by the member Organization to lead normally to a permanent appointment; or
>
> (ii) An appointment which will extend his period of employment to or beyond five years.[68]

A participant enjoys all the benefits of the Fund provided that he is under sixty years of age upon his initial appointment and the terms of his employment do not specifically stipulate for the exclusion of the appointee from participation in the Fund.

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[68] United Nations, United Nations Joint Staff Pension Fund: Explanatory Booklet (JSPB/G.7?Rev.2, January 1, 1963), P. 3.

Full-time staff members who are not eligible to become participants in the Fund, are entitled to join as associate participants provided that they hold an appointment of more than one year and less than five years, or receive subsequent to their initial appointment of less than one year, an offer for one year or more or has completed a full year of service. Entitlement for associate participation is conditioned also by the provisions that the staff member is under sixty years of age and was not excluded from participation by virtue of his terms of appointment.

Associate participants are not eligible for retirement benefits or withdrawal settlements and the entitlements are restricted to disability and survivors benefits. The benefits of the Fund for associate participants cease at the age of sixty.

> A participant pays, by way of contribution to the Fund, seven per cent of his pensionable remuneration while his organization pays fourteen per cent. An associate participant pays no contributions himself but his organization pays four and a half per cent on his behalf.
>
> The participants own regular seven per cent contributions to the Pension Fund, with compound interest at the rate approved by the Board; Two and a half per cent for contributions from the year 1946 to 1957, three per cent from 1958 to March 1961 and three and one-quarter per cent from April 1961 until further notice.[69]

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[69] Ibid., P. 6.

Exclusion of a staff member from joining the Fund as a participant or associate participant is governed by two main reasons: A stipulation in the terms of appointment excluding full or associate participation of the staff member or the period of appointment is specified for a period of less than one year.

The Regulations of the United Nations Joint Staff Pension Fund, in which the World Health Organization is an effective participant provides for the following retirement benefits which stipulate:

> (a) A participant who reaches the age of sixty shall, upon retirement, be entitled during the remainder of his life to an annual retirement benefit, payable monthly, equal to one fifty-fifth of his final average remuneration multiplied by the number of years of his contributory service not exceeding thirty years.
>
> (b) This retirement benefit shall be not less than whichever is the smaller of:
>
> (i) One twenty-Dollars multiplied by the number of years of his contributory service not exceeding ten; or
>
> (ii) One-thirtieth of his final average remuneration multiplied by the number of years of his contributory service not exceeding ten.[70]

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[70] United Nations, Regulations of the United Nations Joint Staff Pension Fund (JSPB/G.4/Rev.4, January 1, 1963), P. 5.

CHAPTER VI

STAFFING DEVELOPMENT AND OTHER ISSUES

This chapter deals with the status of the staff and the measures adopted by the Agency for their development. The process of developing staff by training and close supervision is a vital personnel phase to create an efficient and trained staff. Thus a detailed analysis of the processes of training and supervision in addition to the career service patterns and the types of actions leading to separation from the service, will be presented.

Training and Supervision

The Staff Rules of the World Health Organization stipulate in connection with the training process:

"Staff members may be given suitable training as determined necessary by the Organization to improve their effectiveness in their current assignments and to prepare them for broader usefulness to the Organization."[1]

Training of employees has gained status as an adequate and essential function of administration for direction of human efforts and systemization of their work. The World

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[1]World Health Organization, Staff Rules (January, 1962), P. 13.

Health Organization manifested an effective awareness of the significance of training programs for development of staff, and the Training and Education Division of the Secretariat of the World Health Organization, conducts a pre-entry briefing and orientation program in addition to the many fellowships which are awarded to staff members to enhance their qualifications and develop further their specialization to enable them cope with the complexities of the technical services rendered by the Agency.

The General Conference of the United Nations Education, Scientific and Cultural Organization authorized the Director-General to conduct a survey concerning the issue of common basic training standards for international civil servants. The resolution requested the Director-General to assemble, clarify and analyze the desirability of all international organizations for the establishment of an international center or institute for training purposes.

A memorandum was despatched to the World Health Organization for explanation and comments on the status of its training program in relation to the following points:

(i) Special schools or similar institutions at present engaged in training international civil servants;

(ii) Plans for the establishment of schools or training centers for international civil servants whether these are sponsored by the Organization in question or have come to its notice as independent studies;

(iii) Practical measures adopted by the Organizations in question for the training of international civil servants, including the Organization of briefing centers for Technical Assistance experts.[2]

The reply of the World Health Organization in the above respect stated:

Regarding points (i) and (ii), Chief, Personnel Section maintained that no special schools or similar institutions for training of the staff are associated with the Agency and the Agency has no plans to set up such institutions.

> With regard to point (iii), the briefing and training of WHO staff of all professions is undertaken within the framework of the Organization during the initial weeks and months of a staff members employment. This briefing is undertaken as a matter of course by the various administrative, medical and scientific sections of the Organization at Headquarters and, additionally, by our regional office staff for those staff members who will be employed away from Headquarters.

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[2] United Nations Educational, Scientific and Cultural Organization, A Common Basic Training for International Civil Servants (9c/PRG/3, September 10, 1956), P. 1.

> This briefing is very extensive and is constantly reviewed by a permanent briefing committee representing various parts of the Organization. It has been our experience that this approach has been very satisfactory and would be extremely difficult to duplicate by any group not directly associated with the Organization.[3]

The objective of the Organization in providing an extensive training and education programme culminates in the following three principles:

(1) To help countries to deal with their shortage of health and medical personnel;

(2) To promote technical skill and knowledge by teaching and demonstration teams, by fellowships and all other available teams; and

(3) To assist in the exchange of scientific information.[4]

Since it is not possible and economical to conduct training programs for all staff of different levels of responsibilities, a briefing program as a pre-entry or pre-assignment training program is given either at Headquarters or at the regional offices to orient the personnel with the local environment. "All new staff members both at Headquarters and in the regional offices,

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[3] Ibid., P. 2.

[4] Official Records of the World Health Organization, The Work of WHO: Annual Report of the Director-General to the World Health Assembly and the United Nations, No.90 (Geneva, 1959), P. 24.

receive individual briefing which takes account of many factors, example, the nature of the assignment, its location and historical background, and the new staff member's previous experience."[5]

Programs concerning the geographic social, economic and cultural characteristics of particular countries or regions are briefed to the staff who are destined to the region. Further specialized technical instructions in the field of health are illustrated, and a training program for the languages spoken in the particular area is organized.

> Among United Nations Organizations, only WHO, has yet inaugurated a programme of refresher training for its permanent staff. From 1950 through 1958 with the aid of support from the Rockefeller and Kellogg Foundations, WHO was able to provide special leaves of absence, for a year of advanced study at universities and research institutes, to some thirty of its staff members, Among the groups were several public health administrators and medical specialists who at the time were stationed at regional offices.[6]

Leaves for purpose of refresher training programs are applied for by the staff, but it is expected that in

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[5]World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 108.

[6]Walter R. Sharp, Field Administration in the United Nations System (New York: F.A. Praeger, 1961), P. 243.

the future the Director-General will request staff members to take special leave for advanced study in the interest of the Agency as small funds are being allocated in the budget for such purposes.

Training of staff for administrative and secretarial posts with integrated curricula is provided, and regular training courses for technical staff are held at the Tuberculosis Research Office in Copenhagen.

The comprehensive system of fellowships which is extensively conducted by the World Health Organization for further studies and training of its staff, the Agency acts as a coordinator and has not established its own training institutions.

> It has found countries everywhere eager to offer services and institutions for the instruction of WHO fellows, and to supply teachers to go to other countries that needed help in launching or improving their own teaching. To use existing local resources in this way has proved better, technically, administratively, even psychologically, than the establishment of special international centers and institutions.[7]

The total number of fellowships awarded by the Agency from 1947 till 1962, which are devoted either

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[7]World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 108.

for exclusive training of public health staff or medical teaching in clinical and basic sciences, amount to 15,167 fellowships. Table 15 gives the number of fellowships awarded annually by the Agency to staff members during the period 1947 to 1962. The number of fellowships awarded during 1961 and 1962 by regions and subject of study appear in Appendix J. The leading region which receives the highest number of fellowships is Europe and then the Eastern Mediterranean Region.

TABLE 15

TOTAL NUMBER OF FELLOWSHIPS AWARDED DURING 1947 - 1962*

YEAR	TOTAL NUMBER OF FELLOWSHIPS
1947	199
1948	228
1949	224
1950	396
1951	662
1952	1,143
1953	904
1954	716
1955	1,020
1956	904
1957	1,086
1958	1,339
1959	1,431
1960	1,006
1961	2,157
1962	1,752
Grand Total	15,167

*Official Records of the World Health Organization, The Work of WHO: Annual Report of the Director-General to the World Health Assembly and the United Nations (Geneva, 1947 - 1962).

> In recent years, the World Health Organization with the assistance and collaboration of other Organizations has taken yet another step in its policy of training personnel. It has sent to particular centers of medical education in the different countries of the World, teams of experts in the field of medical relief and public health for periods ranging from three to four weeks.[8]

In addition to the briefing of pre-entry training programs and the training of staff abroad in institutions, the Agency maintains on the job training programs by the close supervision which is exercised by the supervisors.

> Supervisors shall be responsible for facilitating the adjustment of a staff member to his new work situation by:
>
> (a) Providing him with a clear statement of his duties and his official relations;
>
> (b) Interacting and guiding him in learning to perform his functions;
>
> (c) Introducing him properly to those staff members with whom he will be required to work;
>
> (d) Discussing with him at frequent intervals his progress in learning the work.[9]

Further, a periodic formal evaluation report on the performance, conduct and potentialities is prepared and signed by the supervisor on a standardized form. The

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[8]Arcot Mudaliar, "World Health Problems," International Concilliation, 493 - 498 (September, 1963 - May, 1964), 252.

[9]World Health Organization, Staff Rules (January, 1962), P. 13.

periodic reports may be made in accordance with the requirements of the work situation and staff performance and are consequently discussed with the staff member by pointing out the specific unsatisfactory aspects in his performance and give suggestions for improvement. The staff member is entitled to review the report, sign it and attach to it a supplementary statement in which he presents his dissenting views concerning the points set forth in the report.

> The evaluation of performance as reflected in these reports shall be the basis for assisting the staff member to make his most effective contribution to the work of the Organization and for decision concerning the staff members status and retention in the Organization.[10]

Job Tenure

"To provide an attractive career for able persons and, at the same time, to avoid stagnation, is not easy, nor is it possible to elaborate a satisfactory compromise in advance."[11]

A basic human instinct of a staff member is to minimize the conflicts, risks, stresses and uncertainties on the job

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[10] Ibid., P. 13.

[11] Tien-Cheng Young, International Civil Service: Principles and Problems (Brussels: International Institute of Administrative Sciences, 1958), P. 141.

and to secure mental, physical and spiritual security. On the other hand, the Organization must maintain a core of staff with continuity of service and a constant inflow of fresh talents.

The staff of the World Health Organization are classified into two broad categories with different organizational status: Staff holding career service appointments and staff engaged on fixed-term appointments. However, a basic criterion still stands, that, "Unless members of the staff can be offered some assurance of being able to make a career in the Organization it will be difficult to attract able candidates, nor can members of the staff be expected to serve the Organization as loyal international officials if they receive short run contracts."[12]

The highly technical nature of the work of the Agency necessitates the recruitment of a highly qualified and specialized personnel, who unless they receive career service appointments, will not be seduced to abondon their post and join the Agency.

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[12]Adrian Pelt, "Peculiar Characteristics of an International Administration," Public Administration Review, VI (Winter, 1953), P. 111.

A career service appointment is a permanent appointment without a time limit and is granted upon the satisfactory completion of the probationary period of two years. Further, career service appointments possess other safeguards such as adequate allowances, leave, benefits and pensions. The security of tenure is guaranteed by the right of a staff member to appeal to an impartial body in case of grievance.

> In WHO initial contracts for field project staff both on regular budget and Expanded Programme of Technical Assistance, funds are, in most cases, limited for two years, extendable for two years more. Since 1957, however, WHO's policy has been moving towards the granting of career service status up to 75 per cent, of the established posts in the Organization. In line with this policy a considerable number of project staff have been give five-year contracts and a few accorded permanent career status.[13]

Separation from Service

The services of a staff member, officially in service with the Agency, may be either terminated by the Agency, or terminated upon the request of the staff member, or upon the mutual consent of both parties.

"Staff members may resign from the Secretariat upon giving the Director-General the notice required under the terms of their appointment."[14]

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[13]Sharp, Op.cit., P. 164.

[14]World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 85.

A staff appointed for one year or more should give three months notice upon resignation. Appointees of less than one year should complete the period of notice specified in their terms of appoihtment. The period of notice may be waived by the Director-General at his discretion.

Staff members who submit premature resignation are susceptible to forfeiture of the entitlement of retaining their rights for transportation at the expense of the Organization, unless such resignation is due to health or emergency reasons.

Premature resignation refers to the irregular violation of the following terms of appointment:

(i) Resignation of staff who hold an appointment of one year of service or more, before completing one year of service;

(ii) Resignation of staff members, before completing six months of service from the date of their return from home leave, or date of qualifying for it;

(iii) Resignation of staff members who are on Schedule S Assignment, that is, for a fixed period, normally of less than five years, before completing six months of service from the date of their return from leave.

The retirement age in the World Health Organization is at the age of sixty, extendable for not more than a one year extension, in the interest of the Agency, but in no case beyond the Age of sixty-five.

The Agency will terminate the services of a staff member who is incapable of performing his duties and responsibilities due to a chronic or recurrent physical or mental impairment.

> The appointment of staff members who are participants in the Staff Pension Fund and who are entitled under the regulations of the Fund to apply for a disability pension shall not normally be terminated for invalidity until the pension rights have been determined. Those who are, entitled to a disability pension shall be retired for disability.[15]

The termination benefits for staff separated for mental or physical disability, shall not exceed in aggregate, together with the benefits, the total of a year's salary.

The termination of staff holding fixed-term appointments is automatic upon the completion of the period of service, unless his appointment is renewed or extended. Fixed-term appointments of one year or more, are entitled

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[15] World Health Organization, Staff Rules (January, 1962), P. 32.

to a notification period of one month and normally three months before the date of expiry of his service, provided it has been decided not to renew the contract of service. Further, a staff member who does not desire to renew his fixed-term contract should notify the Agency at least one month before his expiry date of service.

Staff members holding posts for a limited period may be terminated before the expiration date, provided that the post is eliminated.

Three months notice are given to staff holding a career service appointment and one month to other staff, if terminated under this rule. The indemnity benefits are computed in accordace with Table 16.

TABLE 16

SCHEDULE OF TERMINATION BENEFITS
FOR CAREER SERVICE APPOINTEES*

YEARS OF SERVICE	MONTHS OF INDEMNITY PAY	TEMPORARY FIXED-TERM APPOINTMENTS
3 or less	3	One week of salary for each month remaining in the inexpired position of the contracts but not less than six weeks of salary, up to a maximum of three months' pay.
4	4	
5	5	
6	6	
7	7	
8	8	
9 or more	9	

*World Health Organization, Staff Rules (January, 1962), P. 33.

Staff members may be terminated due to non-confirmation of their appointment upon the elapse of the initial or extended probationary period, due to unsatisfactory service, misconduct, unsuitability for international service, or medical unfitness. A month notice is given to the staff with no indemnity benefits.

A staff member may be terminated due to unsatisfactory service or unsuitability for international service. Unsatisfactory service is attributed to inability to perform the duties and responsibilities of the post satisfactorily, or failure to build up good working relationship and a team spirit with his fellow staff or with the nationals of other nations with whom he is working. A warning and a reasonable period of time for improvement are given to a staff with unsatisfactory service prior to termination. A staff holding a post beyond his capabilities, is not terminated but reassigned to another post in line with his abilities.

Three months notice are given to staff holding career service appointments and one month notice to any other staff, upon their termination for unsatisfactory service. Indemnity benefits under this rule are payable up to a maximum of three months' pay.

Termination of a staff member by dismissal for misconduct is attributed to his violation of the established standards of conduct required from the staff member.

> A staff member absent from duty without explanation in excess of fifteen working days shall be considered to have abondoned his post and his appointment shall be terminated without indemnity provided that the Organization shall make every reasonable attempt to locate such a staff member prior to termination of contract.[16]

Standards of Conduct

Staff members of the World Health Organization have a number of duties and obligations towards the Agency, and enjoy a set of privileges and immunities which are bestowed upon them by virtue of their international standing. An analysis of these standards and the disciplinary measures instituted by the Agency for misconduct will be presented. Further, the relation of the staff member with the Staff Association and with the Boards of Appeal will be discussed.

The Staff Rules and Regulations lay down the basic standards of conduct which the staff are required to adhere to while in official capacity with the Agency.

> The term misconduct shall mean not only any improper action by a staff member in his official capacity, but also any conduct by a staff member, unconnected with his official duties, tending to bring the Organization into public discredit, or any improper use or attempt to make use of his position as an official for his personal advantage.[17]

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[16] Ibid., P. 34.

[17] Ibid., P. 17.

The Staff Rules prohibit a staff member to act as a delegate, observer, or advisor on behalf of his government when he is in official service with the Agency. Further, publication of any article concerning the Agency is not permissable unless approved by the Director-General, Staff members dealing with a business concern by virtue of their official duty and have financial interest in it, should report such interest to the Director-General.

Staff members are forbidden to succumb to any external authority or accept instructions from any government and should abstain from holding any office which is incompatible with the proper execution of their duties with the Agency.

> Staff members shall conduct themselves at all lines in a manner compatible with their status as international civil servants. They shall avoid any action and in particular any kind of public pronouncement which may adversely reflect on their status. While they are not expected to give up their national sentiments or their political and religious convictions, they shall at all times bear in mind the reserve and tact incumbent upon them by reason of their international status.[18]

Official information known to a staff member by virtue of his work with the Agency, should not be disclosed

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[18]World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 82.

or used for his private advantages, neither when he is officially in service or upon separation. Further, resignation of a staff member from the Secretariat is compulsory if a staff runs for candidacy to an office of political character.

Finally, "No staff member shall accept any honour, decoration, favour, gift or remuneration from any government, or from any other service external to the Organization, if such acceptance is incompatible with his status as an international civil servant."[19]

Certain paramount and fundamental characteristics should characterize international civil servants. A Staff member should be discreet, efficient and have an international outlook. Further, loyatly, impartiality and independence are basic requirements of every staff.

International loyalty is the most fundamental characteristic which is provided for by the staff regulations of all international organizations of the United Nations System.

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[19] Ibid., P. 83

The concept of loyalty poses two paradoxical attitudes which a staff encounters, as to whether his loyalty should be to the Agency or to his national country.

The Charter of the United Nations requires its staff to owe their allegiance to the United Nations System and to transcend mere faithfulness to his own country. It is not a negation of national loyalty but an extension of it to a higher level.

> It is essential that officials should be inspired by a sense of loyalty to the United Nations and devotion to the ideal for which it stands and that they should develop an 'esprit de corps' and a habit of daily cooperation with persons of other countries and cultures. Loyalty to the Organization is in no way incompatible with an officials' attachment to his own country whose higher interest he is serving in serving the United Nations.[20]

Staff members shall subscribe in writing to an oath or declaration. The Director-General shall subscribe orally in a public meeting of the World Health Organization and the Deputy Director-General, Assistant Directors-General and Regional Directors will orally subscribe to the Director-General. The oath or declaration stipulates:

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[20] Young, Op.cit., P. 22.

> I solemnly swear (undertake, affirm, promise) to excercise in all loyalty, discretion, and conscience the functions entrusted to me as an international civil servant of the World Health Organization, to discharge those functions and regulate my conduct with the interests of the World Health Organization only in view, and not to seek or accept instructions in regard to the performance of my duties from any government or other authority external to the Organization.[21]

The International outlook, which is complementary to the concept of loyalty, and is required of the staff, is eloquently expressed as "an awareness made instinctive by habit of the needs, emotions and prejudices of the peoples of differently-circumstanced countries, as they are felt and expressed by the peoples concerned accompanined by a capacity for weighing those frequently imponderable elements in a judicial manner before reaching any decision to which they are relevant."[22]

Disciplinary Measures

The Director-General is empowered to institute disciplinary action for staff whose conduct is unsatisfactory. The conditions justifying the imposition of sanctions and the termination of contracts fall into five broad groups:

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[21]World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 83.

[22]C. Wilfred Jenks, "Some Problems of an International Civil Service," Public Administration Review, III (Spring, 1943), P. 105.

(1) If the official is lazy or incompetent;

(2) If the official is disobedient;

(3) If the official is disloyal to the Agency;

(4) If the conduct of the official is such as to affect his good reputation or bring discredit to the Agency for which he works;

(5) If the official shows lack of tact or discretion such as to affect adversely his own reputation or that of the administration for which he works.[23]

Disciplinary measures may take the form of any or a combination of the following action, depending upon the seriousness of the offense:

(a) Oral Warning;

(b) Written reprimand;

(c) Re-assignment to a less responsible post;

(d) Dismissal.[24]

Further, any violation of the prescribed standards of conduct or disloyalty to the Agency will result in automatic summary dismissal.

A staff member is susceptible to suspension, pending investigation, upon the lodging of a charge against him

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[23]Loveday, Op.cit., P. 111.

[24]World Health Organization, Staff Rules (January, 1962), P. 18.

for serious misconduct, provided that it is prima facie well-founded and the staff continuance in office would jeopardize and prejudice the service. Suspension without pay, is reimbursable in case the charge is not vindicated.

Staff members are notified of the charges and are given an opportunity to defend themselves before their reassignment or dismissal. A written notification is sent and a period of eight days is granted for submission of a reply by the staff. No indemnity benefits are payable upon dismissal of a staff for misconduct.

Privileges and Immunities

The officials of the United Nations and the specialized agencies, of which the World Health Organization is a member, are immune, and this privilege is conferred upon them by virtue of Article 105/2 of the United Nations Charter which stipulates that the privileges and immunities granted to the officials are necessary for the independent exercise of their functions in connection with the Organization. The immunities are bestowed upon the officials to prohibit any encroachment on their rights and ensure their fearless representation of the interests of the Agency.

The principles underlying the implementation of the law of immunities to the officials of the World Health Organization are the following:

(1) The international institutions should have a status which protects them against control or interference by any one government in the performance of functions for the effective discharge of which they are responsible to international bodies represented by all nations;

(2) That no country should derive any national financial advantage by laying fiscal charges on common international funds;

(3) The Agency as a collectivity of states members be accorded the facilities of its official business customarily extended to each other by its individual states.[25]

Article Sixty-Seven of the Constitution of the World Health Organization stipulates:

"The Organization shall enjoy in the territory of each Member such privileges and immunities as may be necessary for the fulfilment of its objective and for the exercise of its functions."[26]

The General Assembly of the United Nations, initiated a resolution in 1946, contemplating the unification of the

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[25]C. Wilfred Jenks, International Immunities (London: Stevens and Sons Ltd., 1961), P. 17.

[26]World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 470.

laws of privileges and immunities to govern the officials of the United Nations System and its Specialized Agencies.

In 1947, the General Assembly approved a convention on the privileges and immunities of the specialized agencies, and consequently the First World Health Assembly adopted the text of the convention. Amendments to the convention were effected by the Third, Tenth and Eleventh World Health Assemblies, to suit the Agency in their application.

The text of the convention consists of eleven articles broken down into forty-nine sections.

The First Article determines the scope of the convention and the meaning of certain clauses and expressions. The Second Article provides for the judicial personality of the Agency and states that "The specialized agencies shall possess judicial personality. They shall have the capacity (a) to contract, (b) to acquire and dispose of unmovable and movable property, (c) to institute legal proceedings."[27]

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[27] World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 24.

The Third Article covers immunity of the property, assets and funds of the specialized agencies from legal process, unless the immunities have been waived. The premise, archives and all documents of the Agency are inviolable and the property and assets are immune from any form of interference by the authorities such as search, requisition, confiscation or expropriation. Specialized agencies are immune from any financial controls on the kinds of currency units used and free transfer and conversion of any currency unit. The Agency is exempted from custom duties and taxes levied on its assets, income and property, but should pay all public utility charges. Excise duties and taxes on rate of movable and immovable property are shouldered by the Agency, but charged taxes on important purchases are remitted by the government concerned when possible. Payments on facilities for official communication media are calculated by the government at the same rates accorded to any other government. The official correspondence and all communicative media are immune from cencership and the Agency is authorized to use codes and dispatch its correspondence in a diplomatic sealed pouch.

Article Five confers upon representatives of members while executing their functions or during their journeys a set of privileges and immunities. Immunity from arrest or

detention, seizure of personal property, due process of law in respect of their words and writings, violability of papers and documents. Further, they are entitled to use codes and receive correspondence in sealed pouches, exemption from immigration restrictions, alliens' registration or national service obligation, and currency and exchange restrictions.

The immunities and privileges of officials are enumerated in Article Six. The category of officials to which the provisions of this Article apply, are specified and conveyed by the Agency to the respective governments.

The officials are immune from the due process of law in respect of their words and writings and immigration restrictions and alliens' registration together with their dependants. They are exempted from taxes on salaries and emoluments and charges on furniture and personal effects. Further, privileges in respect of exchange and repatriation facilities should be accorded to the officials. Exemption of officials from their national service obligation is confined to those suggested by the executive head and approved by the state concerned. Temporary deferrments in an official's national service may be granted by the respective government upon the request of the Agency.

Annex Seven to the convention on privileges and immunities includes provisions concerning the privileges and immunities for experts of the World Health Organization. Privileges and immunities similar to those conferred upon representatives of members in Article Four, and mentioned in the earlier pages, are bestowed upon the experts.

The convention in Section Fourteen of Article Four, Section Twenty-Two of Article Six and Section Three of Item Two of Annex Seven, state:

> Privileges and Immunites are granted to officials, (Experts and representatives of members), in the interests of the Specialized Agencies only and not for the personal benefit of the individuals themselves. Each specialized agency shall have the right and the duty to waive the immunity of any official in any case where, in its opinion, the immunity would impede the course of justice and can be waived without prejudice to the interests of the specialized agency.[28]

Abuse of privileges or immunities as stated in Article Seven is reported by the state authorities to the Agency concerned for consultation. Upon failure of the consultations, the issue is referred to the International Court of Justice for investigation. The condemnation of the Agency entitles the state to withhold the abused privilege from the Agency.

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[28] Ibid., P. 29.

The abuse of the privileges of residence by representatives of members expose them for deportation provided that such deportation is in accordance with the diplomatic procedure applicable to diplomatic envoys accredited to that country and provided that the Foreign Minister of the country to which the official belongs, approves such an action after he consults with the executive head of the Agency.

Article Eight provides for the use of the United Nations Laissez-Passer by officials of the specialized agencies, which is recognized by the states as a valid travel document with all the privileges and facilities accorded to officials of comparable rank in diplomatic missions.

Article Nine governs the appropriate modes and means reverted to for settlement of disputes, discussed in the preceding pages. Articles Ten and Eleven of the convention provide for the 'Annexes and Application to Individual Specialized Agencies' and 'Final Provisions' respectively.

Appeals

> To guarantee security of tenure there must be some impartial body to which the staff member may appeal in case of grievance. He is legally in a weak position, since his relations with his international employer are not governed by a contract capable of

> enforcement in any ordinary court of law. Even the term contract is something of a misnomer; his rights derive from status rather than from contract.[29]

Termination of staff members on grounds of misconduct, unsatisfactory performance, or unsuitability for the service, may be appealed in writing, within eight days of receipt of the notice, to the Director-General, whose decision is final. The case cannot be processed further through the appeal channels and tribunals.

Termination for medical unfitness and/or physical and/or mental disability may be appealed within eight days from receipt of notice, to the Director-General, who refers the appeal to a medical board of three practitioners for re-examination. The decision of the board is final and the case can only be referred to the Administrative Tribunals.

> A staff member may appeal any administrative action or decision affecting his appointment status on the grounds that the action or decision complained of resulted from one or more of the following factors:
>
> (a) Personal prejudice on the part of the supervisor or any other responsible official;
>
> (b) Incomplete consideration of the facts;
>
> (c) Failure to observe or apply correctly the provision of the Staff Regulations or Staff Rules, or the terms of his contract;

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[29] F.R. Scott, "The World's Civil Service," International Concilliation, 496 (January, 1954), P. 294.

(d) Improper application of the WHO post classification standards.[30]

Appeals concerning the above issues are referred to a Board of Inquiry and Appeal at Headquarters and a regional board of appeal at the regional level. Grievances pertaining to improper classification of posts in the professional category can only be heard by the Headquarters Board of Inquiry and Appeal.

The findings of the Headquarters Board of Inquiry and Appeal are reported to the Director-General, with whom the final decision rests. Regional boards report to the regional directors. The decisions of the Board and the Director-General are disclosed to the appellant by the Director-General, or by the regional directors for cases at the regional levels. Regional appeals falling within the competence of Headquarters Board of Inquiry and Appeal may be delegated to a regional board and the findings are reported to Headquarters' Board for review and authorization.

The Composition of the Headquarters Board of Inquiry and Appeal consists of five members with equal voting powers selected as follows:

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[30]World Health Organization, Staff Rules (January, 1962). P. 36.

(a) A Chairman and alternate chairman appointed by the Director-General after consultation with the representatives of the staff;

(b) Two members appointed by the Director-General and two alternates;

(c) Two members representing the staff, drawn from a panel organized in three groups:

Group I - Staff in grades subject to local recruitment;
Group II - Staff in grades P-1 through P-3;
Group III - Staff in grades P-4 through D-2.[31]

The Board shall include at least one representative from the groups to which the appellant belongs and non from the lower groups. Four representatives to groups I & II are elected biennially, and six representatives for group III, eligible for re-election upon expiry of their term.

> The Regional Board of Appeal shall be composed of three members having equal votes, re-elected as follows: One person and one alternate elected by the staff, and a third member, who will serve as chairman, designated by the Regional Director on the nomination of the two other members.[32]

The appealed case is referred to the appropriate board after it has been considered and finalized by the existing administrative channels. A written appeal should be

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[31] Ibid., P. 37.

[32] Ibid., P. 38.

dispatched to the Board within thirty days from the receipt of the notice, with all the specifications and details.

Based on the recommendations of the regional board, a staff member may appeal the decision of the regional director to the Headquarters Board of Inquiry and Appeal, within thirty days from the receipt of the notification.

The regional director shall consult the Director-General before initiating a decision on a recommendation from the regional board of appeal concerning the interpretation of the Staff Rules and Regulations. Appeals against the regional director's decision are referred to Headquarters' Board of Inquiry and Appeal for review and recommendations to the Director-General for decision.

"Any dispute which cannot be resolved internally, arising between the Organization and a member of the staff regarding the fulfilment of the contract of the said member, shall be referred for final decision of the United Nations Administrative Tribunal."[33]

Only appeals arising out of a dispute on the terms of contract or disciplinary action are receivable

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[33] World Health Organization, Basic Documents (13th ed.; Geneva, 1962), PP. 86 - 87.

by the Administrative Tribunal, provided that all internal appeal procedures have been exhausted and a final decision has been initiated.

Staff Association

Staff members are formally entitled to agglomorate at any office or location in a staff association to pursue their activities and interests and elect their representatives to the Agency to promote the personnel policy and ameliorate their conditions of service. Further, association with the staff of other United Nations Organizations for the development of joint activities is permissable under the staff association rules of the Agency.

The elected staff representatives in their negotiation with the Agency on personnel policies and conditions of service, are formally recognized as the representatives of that group of staff who elected them. Proposals for any alteration in the Staff Rules and Regulations should be referred to the representatives for comments.

The staff associations are authorized to collect voluntary contributions from their members to finance their activities. The Agency assists in financing activities sponsored by the staff association which are deemed

beneficial to the staff provided that the association contributes substantially to that activity. The accounts of staff associations receiving financial assistance from the Agency, are subject to the audit procedures of the Agency.

Staffing Problems

The problems and difficulties encountered in the execution of the personnel policies of the World Health Organization, will be presented as soberly and objectively as possible.

The forthcoming analysis of the personnel problems shall apply to the professional staff holding medium term appointments or more and is not applicable to the same degree to that proportion of local recruits and short-term consultants.

An outstanding difficulty inherent in the personnel policy of the World Health Organization, culminates in the incompatibility of the basic criterion of staffing the Agency. Paradoxically, selection of the international officials as stated in the Staff Regulations, stipulate:

> The paramount consideration in the appointment, transfer or promotion of the staff shall be the necessity of securing the highest standards of efficiency, competence and integrity. Due regard shall be paid to the importance of recruiting and maintaining the staff on as wide a geographical basis as possible.[34]

The paradox of institutional efficiency versus geographical representation, necessitates the sacrifice of one for the other. Selection of staff with different educational, cultural and linguistic background to maintain equitable geographical representation of the contributing state members, renders the machinery of the Agency inefficient. Whereas, manning the Agency with competent qualified personnel irrespective of their nationalities, tends to weaken the international character of the Agency.

The obvious reaction to such a paradoxical situation is that of 'fait accompli'. "So long as all states do not provide an equal level of experience and training necessary for international civil service and so long as there is no mathematical measurement of efficiency, competence and integrity, the question will continue to be one of the main problems of international administration." [35]

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[34] World Health Organization, Basic Documents (13th ed.; Geneva, 1962), P. 84.

[35] Young, Op.cit., P. 229.

An attempt to harmonize between the selection of efficient staff and their adequate geographical representation is very difficult as it is deep rooted from the outset, when the need to build a nucleus of qualified staff was speedily sought from the most fruitful sources of recruitment. However, the Agency has not neglected this chronic problem and great efforts are being exerted to realize the geographic distribution of the staff in the Agency's staffing pattern.

"In 1948, twenty-four of the fifty-six Member States had one or more nationals on the staff roll; by 1957 the comparable figures were fifty-three of eighty-eight Members and Associate members."[36]

In 1960, out of the hundred and one Members and Associate Members, sixty-five nationals were represented on the staff roll.

Although a gradual increase is taking place in the representation of the Member States, yet non-representation or under-representation of many states still stands. This discrepancy is due to the shortage of trained and

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[36]World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 108.

experienced staff. The few qualified staff are needed in their country and the shortage can only be alleviated by conducting long term educational programs for the potential training of the nationals to represent their countries.

> Both the Health Assembly and the Executive Board have shared the Director-General's concern to improve the geographical distribution of the staff of the Organization and the question has been discussed several times by both organs. The Executive Board at its nineteenth session, which considered a special report by the Director-General on the subject, expressed satisfaction with the efforts being made to recruit staff on as wide a geographical basis as possible and considered that it would be inadvisable for WHO to establish criteria for the proportion of staff any nationality should comprise.[37]

The technical difficulties involved in staffing the Agency is a three-folded problem:

> (1) The necessity for maintaining an international character in the staff of the Organization concerned;
>
> (2) The inapplicability of many common selection processes in an international frame of reference;
>
> (3) The difficulty of equiting employment terms and conditions on an international scale.[38]

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[37] Ibid..

[38] Robert I. Biren, "Staffing an International Agency," Public Personnel Review, VIII (July, 1947), P. 123.

The language differences create confusion in the administrative processes and retards progress in formulating operating procedures. The Agency is obliged to adopt the French and English language and to prepare the official nationals and documents in both languages. "Even more difficult is the problem of finding words in the other language that connote exactly what a term mean in the language of the person initiating the statement."[39]

Further, the variation in the concepts of organization and schools of administration among nations, prejudicially effects the administrative behaviour of officials towards the personnel phases in particular and the administrative policies in general.

The utilization of common selection standards by international agencies are not always feasible. The advances in psychometrics, interviewing techniques and personality inventories are not applicable at world wide selection level.

> The selection of personnel for international agencies will for some time be made on the basis of analysis of applicants, reference and collateral investigations and, when practicable personnel interviews. These are in general the devices which have been

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[39] O. Glenn Stahl, Public Personnel Administration (Oxford: Clarendon Press, 1956), P. 563.

> considered the weakest of those used for personnel selection. On an absolute basis, perhaps results, have been and will continue to be less satisfactory than the importance of the functions desire.[40]

The staffing problems arise from the application of the accepted recruitment and selection devices. The different techniques utilized by the member states pose many problems in recruitment and selection of the personnel on a world wide basis. The different nationals, who had different orientation programs, educational backgrounds and languages constitute a reservoir of personnel problems.

The staff difficulties are attributed to the nature of the work which is to be performed by the staff of the World Health Organization. The staffing potentials and qualifications should be of the highest calibre and experience to enable them to cope with the universalistic standards and specialized contents of the work.

> The special nature of service with WHO, the conditions in which much of the work has to be done, the relative uncertainty of the possibility of making life career and of settling with security in a suitable station, and, finally, the comparative

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[40] Biren, Op.cit., P. 125

> lack of opportunity for increasing technical skills by continuing study or research are all obstacles to be overcome in securing candidates of the highest competence.[41]

Specific recruitment problems confront the Agency, in addition to the limitations imposed and difficulties confronted by the recruitment machinery procedures. Among these are:

(1) The impact of unrealistic job description for technical assistance;

(2) Shortages of available talent in important professional areas; and

(3) Delays in the acceptance of experts for appointments.[42]

How to obtain and check the reliability of the information regarding a candidate living away and whether the information provided is reliable, is a difficulty which faces the personnel unit of the Agency.

"The Agency practices differ as to the advisability or not of assigning nationals of host countries as directors of field offices. Although the appointment of non-nationals is accepted as a principle, numerous exceptions to the rule have been made for political and other reasons. The heads

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[41]World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P.107.

[42]Sharp, Op.cit., P. 130.

of three of WHO's regional offices at Washington, Alexandria, and New Delhi - were for years nationals of the United States, Egypt, and India, respectively."[43]

The problems eminating from selection from inside the service are primarily attributed to difficulties of adaptation by the staff to the changing environmental conditions due to change in his status.

The different environmental conditions of the staff are manifested in their behaviour on the job. The regional differences within a country in the standards of pay, leave and working conditions, lead to confusion and difficulty in recruiting competent staff. The differences in tradition between various world regions are greater and more serious in their effects on recruiting programs. Candidates for international posts think in terms of their own environment and tend to seek the conditions to which they are accustomed. This situation makes negotiations with potential employees difficult and raise numerous problems in the formulation of the terms of employment.

Appointees for field services should possess the necessary personality traits to facilitate their adjustment

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[43] Ibid., P. 137.

to the different cultural patterns. "In WHO, a number of cases have been reported where medical scientists, of acknowledged competence, have had difficulty in communicating their methods to members of an international team with different cultural origins from their own."[44]

The promotion policy is hindered by obstacles inherent in the terms of the Staff Rules. Priority for filling a vacancy is by promotion of qualified staff from inside the service provided that due regard is paid to the geographical distribution of the staff and the inflow of fresh talent at the various levels of the Agency. "The necessity of observing geographical distribution in the appointment of staff and the maintenance of a balance of nationalities throughout the service necessarily limits the possibilities of normal promotion."[45]

The policy of interchange of staff between Headquarters and the regions and between the regional offices themselves, poses serious difficulties as regards the status and morale of the staff.

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[44] Ibid., P. 144.

[45] Pelt, Op.cit., P. 112.

The problem of interchangeability of staff between Headquarters, and the respective regions was stated by a Norwegian Delegate to the Seventh Health Assembly in 1954, "Who expressed the fear of 'real danger' that the staff at Headquarters might develop into what he described as 'desk people', living in beautiful Geneva, with a standard of living far above that prevailing in the countries needing WHO assistance and under constant stultifying pressure of desk work."[46]

Although the reluctance of Geneva staff to accept assignement at the field level is dying out, yet some of the 'old hands' still find Geneva the most convenient station and consider themselves superior to the field staff by virtue of their station at the central level. The Agency realized that forced transfer of a staff is disruptive to their morale although the Staff Regulations provide for assignment of a staff anywhere in the interest of the Agency. "Nevertheless, according to information supplied by the WHO personnel Division, nearly 40 per cent of the professional staff at Headquarters (as of October 1958) had had some kind of field experience with the Organization."[47]

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[46]Robert Berkov, The World Health Organization: A Study in Dedentralized International Administration (Geneva: Librairie E. Droz, 1957), P. 123.

[47]Sharp, Op.cit., P. 159.

Inter-regional transfers of staff among the respective regions is hampered by technical and language difficulties. A staff engaged in one region cannot be equally useful in another region due to the different linguistic, cultural and health considerations. "Further, the decentralized system of regional appointments, which in effect gives a regional director the right to veto a candidate from another region when proposed by headquarters, does not always facilitate inter-regional transfers."[48]

The policy of decentralization implemented by the Agency has outstanding impacts on the personnel phase.

> A growing difficulty in staff administration is the far-flung nature of the Organization's Operations. With the development of assistance projects, WHO now has some five hundred and fifty officers working in over a hundred places, in addition to the thousand or so working in established offices. This wide dispersion increased the problem of maintaining a sense of unity among a staff of diverse professional and national backgrounds. Every aspect of administration - communication, training, planning and reporting - is being applied to the satisfactory solution of this question.[49]

The functional and geographical decentralization of the operations required an increase in the staff force

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[48] Ibid., P. 159.

[49] World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1948), P. 108.

and consequently multiplied the personnel problems. The problesm of the cost and quality of the staff needed for supervisory positions to ensure effective control eminated with the gradual transformation of the Agency's centralized policy to a decentralized one with greater delegation of authority to the distant areas. Further, the physical disparity raised additional expenses of communication and transport of staff. Formal reports and correspondence between Headquarters and the regions can hardly replace the understanding which results from personal discussions and contacts.

> Headquarters staff members frequently feel that regional action on projects, initial planning and actual budgeting of the regional projects, present them with accomplished facts. Advice on the worth of a project already included in preliminary program and budget estimates is often felt to be useless, since the regional committee has already approved its inclusion in the program of the region.
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> The regional offices and their personnel, on the other hand, and the personnel engaged in field projects, often tend to become impatient with certain Headquarters procedures.[50]

The compensation policy of the World Health Organization, based on the salary scale and the related allowances

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[50] Berkov, Op.cit., P. 105.

and benefits, permits for a wide variation and fluctuation in the income of the staff. The salary scale, appearing in Table 11, indicates that the pay levels overlap in the higher grades. Thus the base salary of a post of grade P-4 step VIII is equal to that of a post of Grade P-5 step I. Further, the staff remunerations are affected by many extraneous factors such as post adjustments, allowances and benefits. Thus an incumbent of a professional post may earn more than another incumbent holding a similar post due to the difference in their duty station, entitlements and cost of living considerations. An official stationed outside his national home is entitled to a post adjustment, expatriation or non-residence allowances, assignment allowances and others. Further, the marital and dependancy status of a staff affects his salary. These extraneous financial effects which finally shape the income of the staff contradict with the principle of equal pay for equal work.

> The task developing a compensation structure that will provide equitable treatment for international staff on field assignments involving similar professional skills and responsibilities is an extraordinary complex one. This complexity derives partly from differences in staff grading standards and salary levels without different agencies, and partly from variations in cost of living at different duty stations.[51]

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[51] Walter R. Sharp, Field Administration in the United Nations System (New York: Fredrick A. Praeger, 1961), P. 145.

The training and briefing programs which are supposed to promote cultural adjustment and psychological security of the staff on the job, are comparatively underdeveloped and lack the systematic attention which should be given either by the Agency or by the countries providing the experts. Recently, the Agency started allocating a modest fund in the budget to send staff for advanced study at universities and research institutes. The Agency does not have neither its training centers nor is engaged with outside institutes and the major portion of its training activity is restricted to an in-service orientation and briefing programs in the initial period within the framework of the Agency. Although a long run training program is the ideal method for developing and nourishing the staff, but such an approach is very expensive and time consuming. The lack of a profound training and development methods poses the problem of maintaining a technical staff equipped with the necessary experience and knowledge of all the new developing methods and techniques, while the Agency can only offer few opportunities to its staff to refresh their scientific knowledge.

"The inevitable result is a relatively high turnover, which, indeed, must even be encouraged of certain classes of highly specialized medical and scientific officer. This adds to the difficulty of recruiting in fields where there are already few suitable workers available."[52]

The problems eminating from misconduct of staff are attributed to the abuse or contravention of the rules prescribed by the convention of privileges and immunities enjoyed by officials of the Agency, thus bringing discredit to their Agency, or by violation or failure to observe the local laws and police regulations of the country in which they are residing.

The problem of disloyalty to the Organization is usually due to conflict on a project or a health issue between the Agency and the national government of which the staff is representing.

"Reference is sometimes made to possible conflicts between national and international loyalties. If such circumstances should arise, the conduct of the international organization and any appearance of disloyalty to that organization must be considered incompatible with his status."[53]

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[52]World Health Organization, The First Ten Years of the World Health Organization (Geneva, 1958), P. 107.

[53]Young, Op.cit., P. 26.

PART IV

SUMMARY AND CONCLUSIONS

CHAPTER VII

CONCLUSION

The foregoing chapters of this study entailed a detailed presentation of the different phases of the World Health Organization as an international decentralized institution. An exposition of the structural features and administrative implications supplemented by an objective analysis of the problems encountered in each of the phases was surveyed. In the following pages, an attempt will be made to evaluate and assess the implemented administrative system of decentralization and consider the developments and future prospects of the Agency.

The need for international action acquired increasing recognition by the peoples of the world, in the last two decades, as the only feasible method to cope with the many social and economic hazards threatening the welfare of mankind. Consequently, efforts were geared to create a number of international institutions each responsible in its field of competence for the promotion of the economic and social advancement of all peoples. The World Health Organization prompted by the existance of Four Health Organizations, which could not satisfy the critical health needs of the people, came into being as a permanent Organization on September 1, 1948.

The structural set up of the Agency has manifested a steady progress over the last fifteen years. The World Health Organization has witnessed an incredible increase in its active membership, financial status and strength of its staff. Further, it has realized an unprecedented progress in the fields of health and medical research and an extensive expansion in the geographical proximity of the operations encompassed by the Agency.

The increasing vigorous physical and financial support of the member states, aided the Agency in operating with an increased staff capacity in a wider decentralized scope and fields of competence, and strengthened the ethical standing and continuity of the mission of the Agency.

The progress which has been achieved in the fields of Health and Medicine, is manifested in the quality of the recent technical programs undertaken by the World Health Organization. The programs, outstandingly covered such subjects as Radiation, Atomic Energy in relation to Health, Antibiotics and Insecticide Resistance. Further, the Agency has supported strongly the health research and concentrated particularly on research pertaining to Communicable Diseases, Cancer and Cardiac Ailments.

Peoples and governments of the world have manifested a growing participation and awareness in the significance of better health standards as a stimulant of economic development and social welfare. The progressive motivation of the undertaking of health projects by the Agency in the distant areas, was intensified by the responsive vigilance of the communities and safeguarded by the reinforcement of the strategy of decentralization in the headquarters of the respective field offices.

Centralization was the dominant feature of the United Nations System and the specialized agencies. Currently, a transformation in many of the administrative systems has occured. Decentralization, has been implemented and used in different contexts. It has been used rigidly to refer to the establishment of a field machinary per se, or to the transfer of headquarters staff to the regional levels. Further, the concept was coined to designate the act of delegation of authority commensurate with responsibility to the operational levels, or to a combination of the above correlations.

The scope of the concept in international organizations ranges from the handling of the restricted procedural matters pertaining to the execution of the prescribed plans

and established programs, to the regional offices of the World Health Organization which handle the program formulations and assume an administering role at the regional levels.

The decentralized system of the World Health Organizations, may be distinguished as a unique administrative pattern in the horizon of international administration, which is geographically and functionally decentralized.

However, it should be pointed out that it is very difficult to draw a line of demarcation between centralization and decentralization. The fact that the World Health Organization runs on a decentralized basis does not eliminate completely the centralized patterns, but simply minimize or dilute the effect of centralization and enhance the decentralized policy. Certain activities and services are still centralized at the Headquarters level and the Agency proves to be reluctant in delegating full administrative and technical autonomy to the operational level to avoid disintigration or fragmantation in the Agency.

The historical development of the administrative pattern implemented by the Agency indicates that an

evolutionary change in the administrative system has occured in a short period after the establishment of the Agency. The administrative system which was initially based on a regionalized pattern, was accompanied by true decentralization of the operations as reflected by the genuine authority and responsibility delegated by Headquarters and exercised by the respective regional offices. An appreciable degree of authority and responsibility was delegated to the operational levels for the management of the financial and personnel matters and supervision of the administrative and technical operations at the regional levels. Further, a gradual change was effected in the regional programs and policies simultaneous with the structural reform which was the by-product of the decentralized policy. Area representatives acting as coordinators and liaison officers are designated by Headquarters to maintain the flow of the operations within the framework of the high policy of the Agency and control and redress any irregularity which might arise. The degree of decentralization in the Agency did not halt at the regional offices, but extended to the sub-units of the regional levels, known as area or zone offices, which are accountable to the headquarters of the regional levels.

The delegation of powers and functions to the periphary, has its pros and cons. Considerable number of benefits and defects have accrued.

The increasing decentralization of the Agency's activities has adapted the programs to the outcrying needs and conditions of the areas. The adaptation policy which was primarily a by-product of decentralization is considered as an asset to the Agency. Further, the contributing governments felt more involved in the projects undertaken by the Agency at the regional levels as their direct interests were effected. A third benefit is the greater experimentation which the Agency has acquired from its decentralized policy by operating in a greater number of areas with different environmental health conditions and problems.

The decentralized policy is not implemented with much sacrifice of control by Headquarters. The programs and budget estimates proposed by the regional levels require the approval of the Director-General. Further, administrative and financial officers are appointed at the regional levels for control purposes. On the other hand, the liabilities incurred by the decentralized policy should likewise be considered.

The uniformity of the Agency's policy at the operating levels is bound to be effected due to differences in the structure, health problems and the physical disparity between the regional offices and the Central Level.

A second arguement against decentralization is attributed to the difficulty of rendering the needed technical services and advice which is highly centralized at the central level due to the multiplicity and complexity of the operations at the regional levels.

A third liability of the decentralized policy is the tendency of the regional levels to influence favourably the perception of the central units about the needs and conditions of the area.

The decentralized policy of the Agency is a more costly process and produces communication problems. The Agency had to strengthen its communication media between the Central Level and the regional offices. The physical disparity generates communication difficulties and distortions. Further, reports and written instructions can never replace human contacts and the necessity for frequent field visits is an expensive policy. However, advocates of decentralization state that the additional statutory and administrative costs incurred by the Agency are compensated for by the effectiveness and efficiency of the operations.

The financial policy of the World Health Organization is a lengthy and cumbersome process as the budget cycle of

preparation, development and implementation of a program for a fiscal year, extends over a period of three years. The preparation, scrutiny and screening of the program formulations and budget estimates originate at the operational levels and has to pass through the many higher levels of the hierarchy for further consideration and authorization. However, the commencement of the initial stages of the budgetary cycle at the regional levels substantiate the reliability of the appropriation decisions which has to be initiated at Headquarters, since the compiled budgetary data is based on the real needs of the community and the orderly growth required by the governments of the regions.

Budgetary problems are augmented by the decentralized policy practised by the Agency. The delay in receipt of the assessments from active members is hindered by the legislative processes of the national governments and the difficulty in determining the adequate regional budgetary allotments is another serious budgetary problem. The scope, extent and number of operational activities which need the financial assistance of the Agency, are far beyond its budgetary potentialities and resources. However, the financial limitations and weaknesses encountered by the Agency are not attributed to the financial system adopted,

but simply are a by-product of the limited sources of finance which are primarily dependent upon the sheer willingness of the member states to contribute and bolster the mission of the Agency more effectively.

The World Health Organization, despite its merits, still suffers from basic weaknesses. The budget of the Agency is woefully small if compared with the budget of the United States Public Health Service and considered in relation to the many and variable health needs and grievances which need the Agency's services. The Agency has no binding authority on the member states against their will especially when the services of the Agency conflict with the national customs and religious beliefs of the country. The Agency operates and channels its plans through the health ministries of the respective countries and as such tremendous powers and hindrances can be exerted by the authorities. The fixed budget of the Agency causes many administrative obstacles, as the operating levels endeavour to squeeze their proposed programs within the framework of the limited budgetary potentialities of the Agency.

The Staff Rules and Regulations of the World Health Organization, which govern the different personnel phases of staffing, compensation and development of the Agency's staff force, are a representative sample of the broad personnel principles applicable to international institutions. The Staff Rules and Regulations are designated to man the Agency with a welded corps of officials who are exclusively international in outlook, professional in background and genoursly remunerated, in order to maintain the paramount considerations of competence, integrity and geographic representation. The personnel policies of the World Health Organization were influenced by the progressive decentralization of the operations to the distant and backward areas. Area and zone offices, equipped with advisory and technical experts and administrative staff, were established to cope with the pressing needs of the areas. The multiplicity and complexity of the operations and the expansion in the physical proximity encompassed, paved the way for progressive increase in the staff strength and potential. Further, the rise in the enrollments of active members, is accompanied by a more geographic representation of the staff on the cadre in order to preserve the international character of the Agency.

However, although the Agency's invulnerable mission of ameliorating and promoting the health conditions of mankind

is an insurmountable and worthy goal, nations of the world have not so far expressed a moral obligation of their fullest support for the basic objectives of the Agency. The World Health Organization may be regarded to be still in the embroyonic stage as a world institution. Nevertheless, the progress achieved so far is considered to be tremendous when compared with the limitless health needs of the human race.

> One cannot measure the time and effort required to accomplish the immediate objectives, let alone the ultimate goal of assisting the individual, regardless of his station in life, to arrive at the highest level of health. What is needed is the joint determination of all countries to make available the necessary resources in the struggle to assist less privileged human beings.[1]

Despite the prominant advances which has been attained by the Agency in its field of competence, the future prospects depend upon and are effected by the critical rifts in the climate of world politics and the sheer willingness of the peoples and governments of the world to collaborate effectively in bolstering the objectives of the Agency and facilitating the execution of its activities. Thus, unless the ideological cleavage between the major political powers in particular and

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[1]Stephen S. Goodspeed, The Nature and Function of International Organization (New York: Oxford University Press, 1959), P. 476.

the world political climate in general aggravates drastically, the World Health Organization will continue to elicit the cooperation and understanding of the national sovereign states and nourish the general health conditions of the human race.

> We do harm to exaggerate its powers. It must work for, with and through governments, each being responsible for the health of its own nation. It has no magic remedy except goodwill. WHO cannot itself do the job. It can, generally, do no more than advice and guide. Except in limited fields of demonstration, it is debarred from active public health work and must function as a catalyst to foster the development of public health services and to build up international collaboration where this is necessary to success.[2]

The World Health Organization, an ostensibly colossal institution, standing as a landmark in the annals of international organizations, is an indispensable entity instigating the human race to seek its integrated endeavours to minimize the hazards and menace of disease. The degrees of scientific progress which the Agency will attain in the coming decades, cannot be foreseen or determined by international bodies, but simply depends on the support of the governments and peoples of the world.

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[2] B.A. Wortley, The United Nations: The First Ten Years (London: Manchester University Press, 1957), P. 137.

A P P E N D I X E S

Appendix A

Constitution of the World Health Organization

The States Parties to this Constitution declares, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundemental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundemental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

Appendix A (Cont'd)

Accepting these principles, and for the purpose of cooperation among themselves and with others to promote and protect the health of all peoples, the Contracting Parties agree to the present Constitution and hereby establish the World Health Organization as a specialized agency within the terms of Article 57 of the Charter of the United Nations.

Chapter I - Objective

Article 1

The objective of the World Health Organization (Hereunder called the Organization) shall be the attainment by all peoples of the highest possible level of health.

Chapter II - Functions

Article 2

In order to achieve its objective, the functions of the Organization shall be:

(a) to act as the directing and coordinating authority on international health work;

(b) to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate;

(c) to assist Governments, upon request, in strengthening health services;

(d) to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments;

(e) to provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories;

(f) to establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services;

Appendix A (Cont'd)

(g) to stimulate and advance work to eradicate epidemic, endemic and other diseases;

(h) to promote, in cooperation with other specialized agencies where necessary, the prevention of accidental injuries;

(i) to promote, in cooperation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene;

(j) to promote cooperation among scientific and professional groups which contribute to the advancement of health;

(k) to propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective;

(l) to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment;

(m) to foster the activities in the field of mental health, especially those affecting the harmony of human relations;

(n) to promote and conduct research in the field of health;

(o) to promote improved standards of teaching and training in the health, medical and related professions;

(p) to study and report on, in cooperation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security;

(q) to provide information, counsel and assistance in the fields of health;

(r) to assist in developing an informed public opinion among all peoples on matters of health;

Appendix A (Cont'd)

(s) to establish and revise as necessary international nomenclatures of disease, of causes of death and of public health practices;

(t) to standardize diagnostic proceedures as necessary;

(u) to develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products;

(v) generally to take all necessary action to attain the objective of the Organization.

Chapter III - Membership And Associate Membership

Article 3

Membership in the Organization.....

Source: World Health Organization, Basic Documents (13th ed.; Geneva, 1962), PP. 1 - 3.

Appendix B

Regional Membership of the World Health Organization
as of December 1963

1. African Region

Burundi
Cameroon
Central African Republic
Chad
Congo (Brazzaville)
Congo (Leopoldville)
Dahomey
Gabon
Ghana
Guinea
Ivory Coast
Liberia
Madagascar
Mali
Mauritania
Niger
Nigeria
Rwanda
Senegal
Sierra Leone
Union Of South Africa
Tangayika
Togo
Upper Volta

Associate Member

Federation Of Rhodesia And Nyassaland
Uganda

2. Region Of The Americas

Argentine
Bolivia
Brazil
Canada
Chile
Colombia
Costa Rica
Cuba
Dominican Republic
Ecuador
El Salvador
Guatemala
Haiti
Honduras
Mexico
Nicaragua
Panama
Paraguay
Peru
United States Of America
Uruguay
Venezuela

Associate Member

Jamaica

Appendix B (Cont'd)

3. Region Of South East Asia

Afghanistan
Burma
Ceylon
India
Indonesia
Mongolia
Nepal
Thailand

4. Western Pacific Region

Australia
Cambodia
China
Japan
Korea, Republic Of
Laos
Malaya, Federation Of
New Zealand
Philippines
Viet-Nam, Republic Of
Western Samoa

5. European Region

Albania
Austria
Belguim
Bulgaria
Byelorussia SSR
Czechoslovakia
Denmark
Finland
France
Germany, Federal Republic
Greece
Hungary
Iceland
Ireland
Italy
Luxembourg
Monaco
Netherlands
Norway
Poland
Portugal
Romania
Spain
Sweden
Switzerland
Turkey
Ukrainian SSR
Union of Soviet Socialist Republics
United Kingdom of Great Britain
and Northern Ireland
Yugoslavia

6. Eastern Mediteranian Region

Algeria
Cyprus
Ethiopia
Iran
Iraq
Israel
Jordan
Kuwait
Lebanon
Libya
Morocco
Pakistan
Saudi Arabia
Somalia
Sudan
Syria
Tunisia
United Arab Republic
Yemen

Source: World Health Organization, World Health, XV (July - August, 1962), P. 13.

Appendix C

Non-Governmental Organizations in Official Relations with the World Health Organization as at 31 December 1962

Biometric Society
Central Council for Health Education
Council for International Organizations of Medical Sciences
Federation Internationale de Medicine Sportive
Inter-American Association of Sanitary Engineering
International Academy of Legal Medicine and of Social Medicine
International Air Transport Association
International Association for Child Psychiatry and Allied Professions
International Association of Microbiological Societies
International Association for Prevention of Blindness
International Commission on Radiological Protection
International Commission on Radiological Units and Measurements
International Committee of Catholic Nurses
International Committee of Red Cross
International Confederation of Midwives
International Conference of Social Work
International Council of Nurses
International Dental Federation
International Diabetes Federation
International Federation of Gynecology and Obstetrics
International Federation for Housing and Planning
International Federation of Surgical Colleges
International Fertility Association
International Hospital Federation
International Hydatidological Association
International League of Dermatological Societies
International League against Rheumatism
International Leprosy Association
International Organization against Trachoma
International Paediatric Association
International Pharmaceutical Federation
International Society of Blood Transfusion
International Society of Cardiology
International Society for Criminology
International Society for Rehabilitation of the Disabled
International Union of Architects
International Union against Cancer
International Union for Child Welfare
International Union for Local Authorities
International Union against Tuberculosis
International Union against the Venereal Diseases and the Treponematoses

Appendix C (Cont'd)

International Water Supply Association
League of Red Cross Societies
Medical Women's International Association
Permanent Commission and International Association on Occupational Health
World Confederation for Physical Therapy
World Federation of the Deaf
World Federation for Mental Health
World Federation of Nuerology
World Federation of Occupational Therapists
World Federation of Societies of Anaesthesiologists
World Federation of United Nations Associations
World Medical Association
World Union OSE
World Veterans Federation
World Veterinary Association

Source: Official Records of the World Health Organization, The Work of WHO: 1962 Annual Report Of The Director-General To The World Health Assembly And To The United Nations. No. 123 (Geneva, 1963), P.182.

Appendix D

Consolidated Statement of Income and Expenditure for the Financial Year 1962 and Status of Working Capital Fund and Special Funds as at 31 December 1962
(Expressed in U.S.Dollars)

		1962
1.	Balance as at 1 January 1962	
2.	Transfers:	
	(a) From Holding Account to 1962 Budget (Casual Income Appropriated	500,000
	(b) From Miscellaneous Income and Assembly Suspense Account to Finance Supplementary Budget Estimates for 1962	1,256,620
3.	Income:	
	Contributions Received	21,183,091
	Contributions from regular budget to Malaria Eradication Special A/c. proceeds from Malaria Eradication Postage Stamp project	
	Voluntary Contributions received	
	Amount reimbursed by the Expanded Programme of Technical Assistance for Administrative and Operational Services Costs	642,000
	Repayment to Working Capital Fund by three members for 1961 advances to meet emergency purchases	
	Sale of publications, vaccination certificates, films, etc..	
	Voluntary contributions in kind and services	
	Miscellaneous income	
		23,581,711
4.	Obligations	(24,164,650)
5.	Transfers made at 31 December 1962:	
	(a) To cover budgetary deficit	582,939
	(b) From Revolving Sales Fund to miscellaneous income	
	(c) From Malaria Eradication Special Account to Trust Funds (Credits due to member states)	
6.	Balances as at 31 December 1962	

Appendix D (Cont'd)

Working Capital Fund	Holding Account	Assembly Suspense Account	Revolving Sales Fund	Executive Board Special Fund	Malaria Eradication S.F	Voluntary Fund for H.Promotion	Total
2752572	1443757	556839	40000	100000	3325092	1604982	9823242
	(500000)						
	(475049)	(781571)					
551818	79392	433146					22247447
					2000000		2000000
					181303		181303
					424563	572082	996645
							642000
22143							22143
			205937				205937
					165874	24833	190707
	788244				157298	37160	932702
3326533	1286344	208414	245937	100000	6254130	2239057	37242126
			(87338)		(4538656)	(1185353)	(29975997)
(582939)							
	118599		(118599)				
					(473600)		473600
2743594	1404943	208414	40000	100000	1241874	1053704	6792529

Source: Official Records of the World Health Organization, Financial Report: 1 January - 31 December, 1962, No. 126 (Geneva, 1963), PP. 14 and 15.

Appendix D (Cont'd)

Working Capital Fund	Holding Account	Assembly Suspense Account	Revolving Sales Fund	Executive Board Special Fund	Malaria Eradication S.F	Voluntary Fund for H.Promotion	Total
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					2000000		2000000
					181303		181303
					424563	572082	996645
							642000
22143							22143
			205937				205937
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	788244				157298	37160	932702
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(582939)							
	118599		(118599)				
					(473600)		473600
2743594	1404943	208414	40000	100000	1241874	1053704	6792529

Source: Official Records of the World Health Organization, Financial Report: 1 January - 31 December, 1962, No. 126 (Geneva, 1963), PP. 14 and 15.

Appendix E
Statement of Appropriation, Obligations
and Balances for the Year 1962
(Expressed in U.S.Dollars)

APPROPRIATION SECTION	PURPOSE OF APPROPRIATION	APPROPRIATIONS ORIGINAL	APPROPRIATIONS SUPPLEMENTARY
	PART I - ORGANIZATIONAL MEETINGS		
1	World Health Assembly	283,910	7,000
2	Exec. Board and its Committees	180,100	3,950
3	Regional Committees	123,290	-
	TOTAL PART I	587,300	10,950
	PART II - OPERATING PROGRAMME		
4	Programme Activities	12,219,046	967,920
5	Regional Offices	2,314,257	174,763
6	Expert Committees	219,800	-
7	Other Statutory Staff Costs	4,033,794	(133,823)
	TOTAL PART II	18,786,897	1,008,860
	PART III - ADMINISTRATIVE SERVICES		
8	Administrative Services	1,480,650	210,312
9	Other Satutory Staff Costs	455,333	26,498
	TOTAL PART III	1,935,983	236,810
	PART IV - OTHER PURPOSES		
10	Headquarters Building Fund	297,000	-
11	Contribution to the Malaria Eradication Special Account	2,000,000	-
	TOTAL PART IV	2,297,000	-
	SUB-TOTALS - PARTS I, II, III & IV	23,607,180	1,256,620
	PART V - RESERVE		
	Undistributed Reserve	1,683,140	-
	TOTAL PART V	1,683,140	-
	TOTAL ALL PARTS	25,290,320	1,256,620

Appendix E (Cont'd)

APPROPRIATIONS		OBLIGATIONS				
INTERSECTION	EFFECTIVE	LIQUIDATED	UNLIQUIDATED	TOTAL	BALANCE
12,100	303,010	250,025	48,870	298,895	4,115
4,000	188,050	150,320	24,235	174,555	13,495
30,710	154,000	136,635	8,141	144,776	9,224
46,810	645,060	536,980	81,246	618,226	26,835
(222,571)	12,964,395	10,191,794	2,317,126	12,508,920	455,475
20,558	2,509,578	2,302,990	164,078	2,467,068	42,510
2,200	222,000	187,561	33,887	221,448	552
160,034	4,060,005	3,802,866	103,265	3,906,131	153,874
(39,779)	19,755,978	16,485,211	2,618,356	19,103,567	652,411
(14,652)	1,676,310	1,607,756	67,633	1,675,389	921
7,261	489,452	461,689	8,779	470,468	18,984
(7,031)	2,165,762	2,069,445	76,412	2,145,857	19,905
-	297,000	297,000	-	297,000	-
-	2,000,000	2,000,000	-	2,000,000	-
-	2,297,000	2,297,000	-	2,297,000	-
-	24,863,800	21,388,636	2,776,014	24,164,650	699,150
-	1,683,140	-	-	-	1,683,140
-	1,683,140	-	-	-	1,683,140
-	26,546,940	21,388,636	2,776,014	24,164,650	2,382,290

Source: Official Records of the World Health Organization, Financial Report: 1 January - 31 December, 1962, No. 126 (Geneva, 1963), PP.12 and 13.

Appendix E (Cont'd)

APPROPRIATIONS		OBLIGATIONS				
INTERSECTION	EFFECTIVE	LIQUIDATED	UNLIQUIDATED	TOTAL	BALANCE
12,100	303,010	250,025	48,870	298,895	4,115
4,000	188,050	150,320	24,235	174,555	13,495
30,710	154,000	136,635	8,141	144,776	9,224
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(14,652)	1,676,310	1,607,756	67,633	1,675,389	921
7,261	489,452	461,689	8,779	470,468	18,984
(7,031)	2,165,762	2,069,445	76,412	2,145,857	19,905
-	297,000	297,000	-	297,000	-
-	2,000,000	2,000,000	-	2,000,000	-
-	2,297,000	2,297,000	-	2,297,000	-
-	24,863,800	21,388,636	2,776,014	24,164,650	699,150
-	1,683,140	-	-	-	1,683,140
-	1,683,140	-	-	-	1,683,140
-	26,546,940	21,388,636	2,776,014	24,164,650	2,382,290

Source: Official Records of the World Health Organization, Financial Report: 1 January - 31 December, 1962, No. 126 (Geneva, 1963), PP.12 and 13.

Appendix F

Statement of Assets and Liabilities
as at 31 December 1962
(Expressed in U.S.Dollars)

ASSETS

Cash			
At Banks, in post office accounts, and in hand			1,690,577
Investments			
Cash on deposit		12,850,000	
Securities at cost		8,035	12,858,035
Accounts Receivable			
Miscellaneous			
Outstanding Contributions			
Active Members	1,691,354		
Active Members affected by the Provision of Resolution WHA 9.9	5,513,231	7,204,585	
Inactive Members		3,302,657	
Special Assessments		8,638,908	19,146,150
Headquarters Building Fund			
Loan agreements and reimbursement from U.N.			7,628,926
Voluntary Contributions in kind and services			
Malaria Eradication Special Account			
Voluntary Fund for health promotion			544,716
Capital Assets (Real Property)			
Western Pacific Regional Office Building (at cost)		692,290	
African Regional Office, Land and Building (at valuation)		693,878	1,386,168
			US $44, 973,340

Appendix F (Cont'd)

Liabilities

Accounts Payable			
Unliquidated Obligations		2,776,014	
Fellowship Balances brought forward		314,653	
General Reserve Balances brought forward		35,495	3,126,162
Unliquidated Obligations:			
Malaria Eradication Special Account		883,913	
Voluntary Fund for health promotion		287,291	
Headquarters Building Fund		4,695,579	5,886,783
Other accounts payable			835,360
Trust Funds			3,852,230
Building Funds			
Headquarters		3,884,750	
African Regional Office		123,208	3,967,958
Working Capital Fund			
Establishment		4,046,050	
Less: Assessments not received as at December, 1962	719,517		
Advances	582,939	1,302,456	2,743,594
Special Funds			4,048,935
Contributions not received as at 31 December, 1962			19,146,150
Equity on Capital Assets			1,386,168
			US $ 44,973.340

Source: Official Records of the World Health Organization, Financial Report: 1 January - 31 December, 1962, No. 126 (Geneva, 1963), PP. 10 and 11.

Appendix G

Statement of Outstanding Contributions
for 1962 Budget and Prior Years
(Expressed in US Dollars)

Members	1962 Budget			Prior Years			Total Outstanding
	Assessment	Collected	Balance Outstanding 31 Dec. 1962	Balance Outstanding 1 January 1962	Collected during 1962	Balance Outstanding 31 Dec. 1962	
ctive Members							
fghanistan	14,490	970	13,520	11,350	11,350	---	13,520
lbania	9,660	640	9,020	25,046	1,207	23,839	32,859
lgeria	---	---	---	---	---	---	---
rgentina	241,480	16,120	225,360	209,967	---	209,967	435,327
ustralia	391,200	391,200	---	---	---	---	---
ustria	94,180	94,180	---	---	---	---	---
elgium	284,950	284,950	---	---	---	---	---
olivia	9,660	640	9,020	44,130	---	44,130	53,150
razil	22,170	6,480	15,690	175,960	175,960	---	15,690
ulgaria	33,810	33,810	---	87,628	1,435	86,193	86,193
urma	16,900	16,900	---	---	---	---	---
urundi	---	---	---	---	---	---	---
ambodia	9,660	9,660	---	---	---	---	---
ameroon	9,660	9,660	---	---	---	---	---
anada	680,980	680,980	---	---	---	---	---
entral African Republic	9,660	9,660	---	---	---	---	---
eylon	21,730	21,730	---	---	---	---	---
had	9,660	9,660	---	---	---	---	---
hile	57,960	---	57,960	47,300	---	47,300	105,260
olombia	67,610	67,610	---	---	---	---	---
ongo (Brazzaville)	9,660	640	9,020	14,330	14,330	---	9,020
ongo (Leopoldville)	9,660	640	9,020	7,570	---	7,570	16,590
osta Rica	9,660	640	9,020	7,570	6,454	1,116	10,136
uba	55,540	3,710	51,830	58,010	58,010	---	51,830
yprus	9,660	9,660	---	---	---	---	---
zechoslavakia	190,770	103,988	86,782	627,277	---	627,277	714,059
ahomeh	9,660	9,660	---	---	---	---	---
ominican Republic	12,070	800	11,270	9,460	9,460	---	11,270
enmark	130,400	130,400	---	---	---	---	---
cuador	14,490	970	13,520	12,317	9,458	2,859	16,379
l Salvador	12,070	10,260	1,810	---	---	---	1,810
thiopia	14,490	14,490	---	---	---	---	---
ederation of Rhodesia & Nyssaland	4,830	4,830	---	---	---	---	---

Appendix G

Statement of Outstanding Contributions for 1962 Budget and Prior Years (Expressed in US Dollars)

Members	1962 Budget			Prior Years			Total Outstanding
	Assessment	Collected	Balance Outstanding 31 Dec. 1962	Balance Outstanding 1 January 1962	Collected during 1962	Balance Outstanding 31 Dec. 1962	
Active Members							
Afghanistan	14,490	970	13,520	11,350	11,350	—	13,520
Albania	9,660	640	9,020	25,046	1,207	23,839	32,859
Algeria	—	—	—	—	—	—	—
Argentina	241,480	16,120	225,360	209,967	—	209,967	435,327
Australia	391,200	391,200	—	—	—	—	—
Austria	94,180	94,180	—	—	—	—	—
Belguim	284,950	284,950	—	—	—	—	—
Bolivia	9,660	640	9,020	44,130	—	44,130	53,150
Brasil	22,170	6,480	15,690	175,960	175,960	—	15,690
Bulgaria	33,810	33,810	—	87,628	1,435	86,193	86,193
Burma	16,900	16,900	—	—	—	—	—
Burundi	—	—	—	—	—	—	—
Cambodia	9,660	9,660	—	—	—	—	—
Cameroon	9,660	9,660	—	—	—	—	—
Canada	680,980	680,980	—	—	—	—	—
Central African Republic	9,660	9,660	—	—	—	—	—
Ceylon	21,730	21,730	—	—	—	—	—
Chad	9,660	9,660	—	—	—	—	—
Chile	57,960	—	57,960	47,300	—	47,300	105,260
Colombia	67,610	67,610	—	—	—	—	—
Congo (Brazzaville)	9,660	640	9,020	14,330	14,330	—	9,020
Congo (Leopoldville)	9,660	640	9,020	7,570	—	7,570	16,590
Costa Rica	9,660	640	9,020	7,570	6,454	1,116	10,136
Cuba	55,540	3,710	51,830	58,010	58,010	—	51,830
Cyprus	9,660	9,660	—	—	—	—	—
Czechoslavakia	190,770	103,988	86,782	627,277	—	627,277	714,059
Dahomeh	9,660	9,660	—	—	—	—	—
Dominican Republic	12,070	800	11,270	9,460	9,460	—	11,270
Denmark	130,400	130,400	—	—	—	—	—
Equador	14,490	970	13,520	12,317	9,458	2,859	16,379
El Salvador	12,070	10,260	1,810	—	—	—	1,810
Ethiopia	14,490	14,490	—	—	—	—	—
Federation of Rhodesia & Nyssaland	4,830	4,830	—	—	—	—	—

Appendix G (Cont'd)

Members	1962 Budget			Prior Years			Total Outstanding
	Assessment	Collected	Balance Outstanding 31 Dec. 1962	Balance Outstanding 1 January 1962	Collected during 1962	Balance Outstanding 31 Dec. 1962	
Finland	77,270	77,270	—	—	—	—	—
France	1,400,600	1,400,600	—	—	—	—	—
Gabon	9,660	9,660	—	—	—	—	—
Germany, Federal Republic Of	1,166,360	1,166,360	—	—	—	—	—
Ghana	14,490	14,490	—	—	—	—	—
Greece	50,710	50,710	—	—	—	—	—
Guatemala	12,070	800	11,270	—	—	—	—
Guinea	9,660	9,660	—	—	—	—	—
Haiti	9,660	640	9,020	14,330	1,955	12,375	21,395
Hondorous	9,660	640	9,020	7,570	7,500	70	9,090
Iceland	9,660	9,660	—	—	—	—	—
India	538,510	537,781	729	—	—	—	729
Indonesia	101,420	6,770	94,650	—	—	—	94,650
Iran	45,880	45,880	—	—	—	—	—
Iraq	19,320	19,320	—	—	—	—	—
Ireland	33,810	33,810	—	—	—	—	—
Israel	31,390	31,390	—	—	—	—	—
Italy	492,630	—	492,630	389,760	389,760	—	492,630
Ivory Coast	14,490	14,490	—	—	—	—	—
Jamaica	4,830	4,830	—	—	—	—	—
Japan	478,140	478,140	—	—	—	—	—
Jordan	9,660	9,660	—	—	—	—	—
Korea, Republic Of	45,880	45,880	—	—	—	—	—
Kuwait	9,660	9,660	—	—	—	—	—
Laos	9,660	9,660	—	—	—	—	—
Lebanon	12,070	12,070	—	18,620	18,620	—	—
Liberia	9,660	640	9,020	—	—	—	9,020
Libya	9,660	9,660	—	—	—	—	—
Luxembourg	14,490	14,490	—	—	—	—	—
Madagascar	14,490	14,490	—	5,602	5,602	—	—
Malaya, Fegeration of	36,220	36,220	—	—	—	—	—
Mali	9,660	9,660	—	—	—	—	—
Mauritania	9,660	9,660	—	—	—	—	—
Mexico	154,550	154,550	—	—	—	—	—
Monaco	9,660	9,660	—	—	—	—	—
Mongolia	9,660	9,660	—	—	—	—	—
Morocco	31,390	31,390	—	—	—	—	—

Appendix G (Cont'd)

Members	1962 Budget			Prior Years			Total Outstanding
	Assessment	Collected	Balance Outstanding 31 Dec. 1962	Balance Outstanding 1 January 1962	Collected during 1962	Balance Outstanding 31 Dec. 1962	
pal	9,660	640	9,020	7,570	6,760	810	9,830
therlands	219,750	219,750	---	---	---	---	---
Zealand	91,760	91,760	---	---	---	---	---
caragua	9,660	640	9,020	810	---	810	9,830
ger	9,660	9,660	---	---	---	---	---
geria	45,880	45,880	---	---	---	---	---
rway	106,250	106,250	---	---	---	---	---
kista	86,930	86,930	---	---	---	---	---
nama	9,660	640	9,020	7,570	---	7,570	16,590
raguay	9,660	640	9,020	7,570	---	7,570	16,590
ru	24,150	13,742	10,408	9,164	9,164	---	10,408
ilippines	94,180	94,180	---	---	---	---	---
land	299,440	299,440	---	556,529	13,826	542,703	542,703
rtugal	43,470	43,470	---	---	---	---	---
mania	74,860	74,860	---	203,120	4,989	198,131	198,131
anda-Urandi	4,830	320	4,510	3,780	3,780	---	4,510
anda	---	---	---	---	---	---	---
udi Arabia	14,490	14,490	---	---	---	---	---
negal	14,490	14,490	---	---	---	---	---
erra Leone	9,660	640	9,020	3,790	3,350	440	9,460
malia	9,660	9,660	---	7,570	7,570	---	---
uth Africa	123,160	123,160	---	---	---	---	---
ain	202,850	202,850	---	---	---	---	---
dan	14,490	14,490	---	---	---	---	---
eden	304,270	304,270	---	---	---	---	---
itzerland	212,510	212,510	---	---	---	---	---
ria	12,070	800	11,270	---	---	---	11,270
nganyika	9,660	9,660	---	---	---	---	---
ailand	33,810	33,810	---	---	---	---	---
go	9,660	9,660	---	---	---	---	---
nesia	12,070	12,070	---	---	---	---	---
key	127,990	127,990	---	---	---	---	---
anda	4,830	4,830	---	---	---	---	---
ion Of Soviet Socialist Republic	2,979,900	2,979,900	---	4,104,600	69,512	4,035,088	4,035,088
ited Arab Republic	57,960	3,880	54,080	---	---	---	54,080
ited Kingdom & Northern Ireland	1,702,460	1,702,460	---	---	---	---	---

Appendix G (Cont'd)

Members	1962 Budget			Prior Years			Total Outstanding
	Assessment	Collected	Balance Outstanding 31 Dec. 1962	Balance Outstanding 1 January 1962	Collected during 1962	Balance Out-standing 31 Dec. 1962	
Nepal	9,660	640	9,020	7,570	6,760	810	9,830
Netherlands	219,750	219,750	—	—	—	—	—
New Zealand	91,760	91,760	—	—	—	—	—
Nicaragua	9,660	640	9,020	810	—	810	9,830
Niger	9,660	9,660	—	—	—	—	—
Nigeria	45,880	45,880	—	—	—	—	—
Norway	106,250	106,250	—	—	—	—	—
Pakista	86,930	86,930	—	—	—	—	—
Panama	9,660	640	9,020	7,570	—	7,570	16,590
Paraguay	9,660	640	9,020	7,570	—	7,570	16,590
Peru	24,350	13,742	10,408	9,164	9,164	—	10,408
Philippines	94,180	94,180	—	—	—	—	—
Poland	299,440	299,440	—	556,529	13,826	542,703	542,703
Portugal	43,470	43,470	—	—	—	—	—
Romania	74,860	74,860	—	203,120	4,989	198,131	198,131
Ruanda-Urandi	4,830	320	4,510	3,780	3,780	—	4,510
Rwanda	—	—	—	—	—	—	—
Saudi Arabia	14,490	14,490	—	—	—	—	—
Senegal	14,490	14,490	—	—	—	—	—
Sierra Leone	9,660	640	9,020	3,790	3,350	440	9,460
Somalia	9,660	9,660	—	7,570	7,570	—	—
South Africa	123,160	123,160	—	—	—	—	—
Spain	202,850	202,850	—	—	—	—	—
Sudan	14,490	14,490	—	—	—	—	—
Sweden	304,270	304,270	—	—	—	—	—
Switzerland	212,510	212,510	—	—	—	—	—
Syria	12,070	800	11,270	—	—	—	11,270
Tanganyika	9,660	9,660	—	—	—	—	—
Thailand	33,810	33,810	—	—	—	—	—
Togo	9,660	9,660	—	—	—	—	—
Tunesia	12,070	12,070	—	—	—	—	—
Turkey	127,990	127,990	—	—	—	—	—
Uganda	4,830	4,830	—	—	—	—	—
Union Of Soviet Socialist Republic	2,979,900	2,979,900	—	4,104,600	69,512	4,035,088	4,035,088
United Arab Republic	57,960	3,880	54,080	—	—	—	54,080
United Kingdom & Northern Ireland	1,702,460	1,702,460	—	—	—	—	—

Appendix G (Cont'd)

Members	1962 Budget			Prior Years			Total Outstanding
	Assessments	Collected	Balance Outstanding 31 Dec. 1962	Balance Outstanding 1 January 1962	Collected during 1962	Balance Outstanding 31 Dec. 1962	
ed States America	7,657,430	7,657,430	---	---	---	---	---
r Volta	9,660	9,660	---	---	---	---	---
uay	26,560	---	26,560	39,140	18,330	20,810	47,370
zuela	108,670	108,670	---	---	---	---	---
Nam Re- blic Of	43,470	43,470	---	---	---	---	---
ern Samoa	4,830	4,830	---	---	---	---	---
n	9,660	640	9,020	19,215	14,607	4,608	13,628
slavia	77,270	77,270	---	57,343	57,343	---	---
l-Active mbers	22,465,180	21,173,091	1,292,089	6,830,538	536,082	5,894,456	7,204,585
ial Assess- nts China	1,096,340	10,000	1,086,340	7,552,568	---	7,552,568	8,638,908
tive Members elorussian- R	101,420	---	101,420	473,252	---	473,252	574,672
ary	91,760	---	91,760	427,884	---	427,884	519,644
inian SSR	393,620	---	393,620	1,814,721	---	1,814,721	2,208,341
Inactive mbers	586,800	---	586,800	2,715,857	---	2,715,857	3,302,657
- All mbers	24,148,320	21,183,091	2,965229	17,098,963	936,082	16,162,881	19,146,150

Source: Official Records of the World Health Organization, Financial Report: 1 January - December, 1962, No.126(Geneva, 1963), PP.20-22

Appendix G (Cont'd)

Members	1962 Budget			Prior Years			Total Outstanding
	Assessments	Collected	Balance Outstanding 31 Dec. 1962	Balance Outstanding 1 January 1962	Collected during 1962	Balance Outstanding 31 Dec. 1962	
United States Of America	7,657,430	7,657,430	—	—	—	—	—
Upper Volta	9,660	9,660	—	—	—	—	—
Uruguay	26,560	—	26,560	39,140	18,330	20,810	47,370
Venezuela	108,670	108,670	—	—	—	—	—
Viet Nam Republic Of	43,470	43,470	—	—	—	—	—
Western Samoa	4,830	4,830	—	—	—	—	—
Yemen	9,660	640	9,020	19,215	14,607	4,608	13,628
Yugoslavia	77,270	77,270	—	57,343	57,343	—	—
Total-Active Members	22,465,180	21,173,091	1,292,089	6,830,538	536,082	5,894,456	7,204,585
Special Assessments China	1,096,340	10,000	1,086,340	7,552,568	—	7,552,568	8,638,908
Inactive Members Byelorussian-SSR	101,420	—	101,420	473,252	—	473,252	574,672
Hungary	91,760	—	91,760	427,884	—	427,884	519,644
Ukrainian SSR	393,620	—	393,620	1,814,721	—	1,814,721	2,208,341
Total Inactive Members	586,800	—	586,800	2,715,857	—	2,715,857	3,302,657
Total - All Members	24,148,320	21,183,091	2,965229	17,098,963	936,082	16,162,881	19,146,150

Source: Official Records of the World Health Organization, Financial Report: 1 January - 31 December, 1962, No.126(Geneva, 1963), PP.20-22

Appendix H

Geographical Distribution Of Members At the International And Local Levels for The Years 1958-1962

Distribution	1958	1959	1960	1961	1962
A. Headquarters					
Internationally recruited	289	310	320	311	321
Locally recruited	283	293	319	342	364
	572	603	639	653	685
B. Regional Offices					
Africa					
Internationally recruited	15	22	26	32	39
Locally recruited	46	58	71	81	90
	61	80	97	113	129
The Americas					
Internationally recruited	24	31	31	31	32
Locally recruited	35	32	37	32	46
	59	63	68	63	78
South East Asia					
Internationally recruited	30	27	29	32	36
Locally recruited	95	111	114	109	112
	125	138	143	141	148
Europe					
Internationally recruited	34	36	38	38	41
Locally recruited	54	60	61	65	75
	88	96	99	103	116
Eastern Mediteranean					
Internationally recruited	32	38	37	41	35
Locally recruited	66	76	83	75	83
	98	114	120	116	118
Western Pacific					
Internationally recruited	25	26	30	29	29
Locally recruited	54	61	65	65	65
	79	87	95	94	94

Appendix H (Cont'd)

Distribution	1958	1959	1960	1961	1962
C. Area and Zone Offices					
Internationally recruited	11	14	12	18	25
Locally recruited	26	25	28	28	36
	37	39	40	46	61
D. Field Staff In Countries					
Internationally recruited	553	594	597	754	882
Locally recruited	10	26	32	25	23
	563	620	629	779	905
E. Other Offices					
UNICEF Liaison					
Internationally recruited	4	3	4	2	2
	4	4	4	1	2
	8	7	8	3	4
Tuberculosis Immunization Research center, Copenhagen	3	2	1	1	-
UNRWA	3	4	4	4	3
International Children's center, Paris	1	1	1	1	1
	7	7	6	6	4
Staff on loan, on payroll of the Pan American Health Organization or without pay	27	35	34	25	20
Short Term Consultants	80	79	63	102	91
Grand Total	1804	1968	2041	2244	2453

Source: Official Records of the World Health Organization, the Work of W.H.O.: Annual Report of the Director-General to the World Health Assembly and the United Nations (Geneva, 1958 - 1962).

Appendix I

Salary Schedules Showing Distribution of Posts
By Grade Levels in the World Health Organization

A - Internationally Recruited Staff

Grade	Number of Posts									Salary Scale			
	Regular			Malaria Eradication Special Account (Regular)			Expanded Prog. of Technical Assistance			Other Extra - Budgetary Funds			Base U.S. Dollars	Maximum	Number of Steps
	1962	1963	1964	1962	1963	1964	1962	1963	1964	1962	1963	1964			
P-1	102	105	121	15	13	-	12	9	7	41	41	40	4800	6310	IX
P-2	158	161	221	60	66	-	137	125	114	95	94	89	6130	7880	X
P-3	180	199	251	35	42	-	109 (b)	107 (b)	96 (b)	220	222	222	7460	9870	XII
P-4	291	327	456	101	113	-	234	243	219	185	192	196	8930	11420	XI
P-5	137	141	146	1	3	-	21	16	15	38	40	40	10650	13100	X
P-6/D-1	17	17	17	-	-	-	-	-	-	9	9	9	12080	14530	VII
D-2	21 (a)	21 (a)	21 (a)	-	-	-	-	-	-	- (c)	- (c)	- (c)	14530	15520	III
UG	12	12	12	-	-	-	-	-	-	2	2	2			
Total Internationally Recruited Staff	918	983	1245	212	237	-	513	500	451	590	600	598			

(a) Director-General, Deputy Director-General & Regional Directors.
(b) Including Consultants
(c) Assistant Director & Secretary General

Appendix I

Salary Schedules Showing Distribution of Posts
By Grade Levels in the World Health Organization

A - Internationally Recruited Staff

Grade	Number of Posts									Salary Scale					
	Regular			Malaria Eradication Special Account (Regular)			Expanded Prog. of Technical Assistance			Other Extra - Budgetary Funds			Base U.S.	Maximum Dollars	Number of Steps
	1962	1963	1964	1962	1963	1964	1962	1963	1964	1962	1963	1964			
P-1	102	105	121	15	13	-	12	9	7	41	41	40	4800	6310	IX
P-2	158	161	221	60	66	-	137	125	114	95	94	89	6130	7880	X
P-3	180	199	251	35	42	-	109 (b)	107 (b)	96 (b)	220	222	222	7460	9870	XII
P-4	291	327	456	101	113	-	234	243	219	185	192	196	8930	11420	XI
P-5	137	141	146	1	3	-	21	16	15	38	40	40	10650	13100	X
P-6/D-1	17	17	17	-	-	-	-	-	-	9	9	9	12080	14530	VII
D-2	21 (a)	21 (a)	21 (a)	-	-	-	-	-	-	-	-	-	14530	15520	III
UG	12	12	12	-	-	-	-	-	-	(c) 2	(c) 2	(c) 2			
Total Internationally Recruited Staff	918	983	1245	212	237	-	513	500	451	590	600	598			

(a) Director-General, Deputy Director-General & Regional Directors.
(b) Including Consultants
(c) Assistant Director & Secretary General

Appendix I (Cont'd)

B - Locally Recruited Staff

Grade	Number of Posts												Salary Scale		
	Regular			Malaria Eradication Special Account (Regular)			Expanded Prog. of Technical Assistance			Other Extra Budgetary Funds			Base	Maximum	Number of Steps
	1962	1963	1964	1962	1963	1964	1962	1963	1964	62	63	64			
Headquarters (Geneva)													Swiss	Francs	
G-1	-	-	-	-	-	-	-	-	-	-	-	-	10055	13105	XI
G-2	5	5	5	-	-	-	-	-	-	-	-	-	10755	14225	XI
G-3	117	127	135	-	-	-	-	-	-	2	3	3	11590	15890	XI
G-4	127	127	129	-	-	-	-	-	-	9	9	9	12715	17665	XI
G-5	63	63	64	-	-	-	-	-	-	4	4	4	13760	19210	XI
G-6	36	40	41	-	-	-	-	-	-	1	1	1	15080	21130	XI
G-7	10	11	11	-	-	-	-	-	-	-	-	-	16755	24255	XI
	358	373	389	-	-	-	-	-	-	16	17	18			
Total - Recruited Staff of Regional Zone, Field Liaison & W.H.O. Representative' Offices	802	828	880	30	32	-	-	-	-	302	308	314			
Total - Internationally and Locally Recruited Staff	1720	1811	2125	242	269	-	513	500	451	892	908	912			
Total - Unclassified Posts	4	8	14	3	6	-	-	-	-	183	181	180			
Grand Total	1724	1819	2139	245	275	-	513	500	451	1075	1089	1092			

Source: Official Records of the World Health Organization, Proposed Programme and Budget Estimates for the Financial Year 1 January - 31 December, 1964, No.121 (Geneva, 1962), PP. xxiv and xxv.

Appendix I (Cont'd)

B - Locally Recruited Staff

Grade	Number of Posts												Salary Scale		
	Regular			Malaria Eradication Special Account (Regular)			Expanded Prog. of Technical Assistance			Other Extra Budgetary Funds			Base	Maximum	Number of Steps
	1962	1963	1964	1962	1963	1964	1962	1963	1964	62	63	64			
Headquarters (Geneva)													Swiss	Francs	
G-1	-	-	-	-	-	-	-	-	-	-	-	-	10055	13105	XI
G-2	5	5	5	-	-	-	-	-	-	-	-	-	10755	14225	XI
G-3	117	127	135	-	-	-	-	-	-	2	3	3	11590	15890	XI
G-4	127	127	129	-	-	-	-	-	-	9	9	9	12715	17665	XI
G-5	63	63	64	-	-	-	-	-	-	4	4	4	13760	19210	XI
G-6	36	40	41	-	-	-	-	-	-	1	1	1	15080	21130	XI
G-7	10	11	11	-	-	-	-	-	-	-	-	-	16755	24255	XI
	358	373	389	-	-	-	-	-	-	16	17	18			
Total - Recruited Staff of Regional Zone, Field Liaison & W.H.O. Representative' Offices	802	828	880	30	32	-	-	-	-	302	308	314			
Total - Internationally and Locally Recruited Staff	1720	1811	2125	242	269	-	513	500	451	892	908	912			
Total - Unclassified Posts	4	8	14	3	6	-	-	-	-	183	181	180			
Grand Total	1724	1819	2139	245	275	-	513	500	451	1075	1089	1092			

Source: Official Records of the World Health Organization, Proposed Programme and Budget Estimates for the Financial Year 1 January - 31 December, 1964, No.121 (Geneva, 1962), PP. xxiv and xxv.

Appendix J

Fellowships Awarded by Subject of Study & by Region

for 1 September 1960 - 30 November 1961 &
1 December 1961 - 30 November 1962

Subject of Study	Regions															
	Africa		The Americas		South East Asia		Europe		Eastern Mediteranian		Western Pacific		Total			
	1961	1962	'61	'62	'61	'62	'61	'62	'61	'62	'61	'62	'61	'62	'61	'62
I Public Health Administration	15	22	32	11	12	11	87	80	68	30	36	14	250	168		
II Sanitation	13	3	67	44	5	12	67	31	15	10	5	1	172	13		
III Nursing	16	47	28	24	12	10	22	18	33	41	14	13	125	153		
IV Maternal & Child Health	17	12	12	12	1	2	30	35	11	9	6	9	77	79		
V Other Health Services	20	10	73	41	37	12	161	116	80	58	53	53	424	290		
Sub-Total	81	94	212	162	67	47	367	280	207	148	114	90	1048	821		
Percentage	19	23	76	73	40	36	58	61	44	41	57	53	49	47		
VI Communicable Disease Service	79	91	30	28	81	70	118	76	128	101	72	60	508	426		
Percentage	38	22	11	12	49	53	19	16	28	28	36	23	23	24		
VII Clinical Medicine, Basic Medical Sciences & Medical Education																
(i) Clinical Medicine	256	216	7	9	9	7	93	48	119	100	11	13	495	394		
(ii) Basic Medical Sciences & Medical Educ.	1	6	29	24	10	8	53	55	10	3	5	5	106	111		
Sub-Total	257	222	36	33	19	15	146	104	129	113	14	18	601	505		
Percentage	62	55	13	15	11	11	23	23	28	31	7	11	28	29		
Grand Total	417	407	278	223	167	132	631	460	464	362	200	168	2157	1752		

Source: Official Records of the World Health Organization, The Work of WHO: 1962 Annual Report of the Director-General to the World Health Assembly and the United Nations, No. 123 (Geneva, 1963), P. 194.

Appendix J

Fellowships Awarded by Subject of Study & by Region

for 1 September 1960 - 30 November 1961 &
1 December 1961 - 30 November 1962

Subject of Study	Regions															
	Africa		The Americas		South East Asia		Europe		Easter Mediterranian		Western Pacific		Total			
	'1961	'1962	'61	'62	'61	'62	'61	'62	'61	'62	'61	'62	'61	'62	'61	'62
I Public Health Administration	15	22	32	11	12	11	87	80	68	30	36	14	250	168		
II Sanitation	13	3	67	44	5	12	67	31	15	10	5	1	172	13		
III Nursing	16	47	28	24	12	10	22	18	33	41	14	13	125	153		
IV Maternal & Child Health	17	12	12	12	1	2	30	35	11	9	6	9	77	79		
V Other Health Services	20	10	73	41	37	12	161	116	80	58	53	53	424	290		
Sub-Total	81	94	212	162	67	47	367	280	207	148	114	90	1048	821		
Percentage	19	23	76	73	40	36	58	61	44	41	57	53	49	47		
VI Communicable Disease Service	79	91	30	28	81	70	118	76	128	101	72	60	508	426		
Percentage	38	22	11	12	49	53	19	16	28	28	36	23	23	24		
VII Clinical Medicine, Basic Medical Sciences & Medical Education																
(i) Clinical Medicine	256	216	7	9	9	7	93	48	119	100	11	13	495	394		
(ii) Basic Medical Sciences & Medical Educ.	1	6	29	24	10	8	53	55	10	3	5	5	106	111		
Sub-Total	257	222	36	33	19	15	146	104	129	113	14	18	601	505		
Percentage	62	55	13	15	11	11	23	23	28	31	7	11	28	29		
Grand Total	417	407	278	223	167	132	631	460	464	362	200	168	1757	1752		

Source: Official Records of the World Health Organization, The Work of WHO: 1962 Annual Report of the Director-General to the World Health Assembly and the United Nations, No. 123 (Geneva, 1963), P. 194.

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---------- Annual Report of the Director-General to the World Health Assembly and to the United Nations, Geneva:

Years	Numbers
1948	16
1949	24
1950	30
1951	38
1952	45
1953	51
1954	59
1955	67
1956	75
1957	82
1958	90
1959	98
1960	105
1961	114
1962	123

---------- Reports of the Executive Board, Geneva:

Years	Session	Numbers
1951	Seventh	33
1953	Eleventh	46
1954	Thirteenth (Part II)	53
1955	Fifteenth (Part II)	61
1955	Sixteenth	65
1956	Seventeenth	68
1956	Seventeenth	69
1956	Eighteenth	73
1962	Twenty-Ninth (Part I)	115
1962	Twenty-Ninth (Part II)	116
1963	Thirty-First (Part I)	124
1963	Thirty-First (Part II)	125
1963	Thirty-Second	129

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