FIFTH MEETING

Friday, 20 May 2011, at 15:05

Chairman: Dr A.-Z. GOLEM (Croatia)
later: Dr M.T. VALENZUELA (Chile)

1. INTERIM PROGRESS REPORT OF THE WORKING GROUP ON THE ELECTION OF THE DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION: Item 18.6 of the Agenda (Document A64/41) (continued from the fourth meeting, section 2)

Mr JAZAÏRY (Algeria) said that the current procedure for electing the Director-General theoretically allowed Member States to nominate for consideration by the Executive Board one or more qualified candidates for the post. However, in practice, the system was less straightforward. In fact, during the Organization's 63 years of existence, only three of the six regions had nominated successful candidates. The current rules needed to be made more transparent and equitable in order to ensure that all WHO's regions were adequately represented. Certainly, candidates must be competent and of a high calibre, according to the criteria set out in resolution EB97.R10, and the relevant provisions must be upheld of paragraph 3 of Article 101 of the Charter of the United Nations, which referred to the importance of recruiting staff on as wide a geographical basis as possible. Limiting recruitment of Directors-General to half the regions represented, however, hardly met that criterion. As a specialized agency of the United Nations system, WHO was bound to comply with the Charter. Moreover, paragraph 1 of Article XII of the Agreement between the United Nations and WHO stipulated that they should develop as far as practicable common personnel standards. The criteria of competence, expertise and experience should not then override the principle of equitable geographical representation.

Greater involvement by the Health Assembly in the nomination of the Director-General would make the selection process more democratic and transparent. The Board was presently responsible for nominating candidates, but, because of its limited membership, it was not in a position to reflect the views of all Member States. It was time for the system to change: the Health Assembly should be empowered to nominate the Director-General itself, on the basis of a list presented to it by the Board, instead of merely "rubber-stamping" the Board's candidate.

He had welcomed the Board's decision in resolution EB128.R14 to establish a working group on the process and methods of the election of the Director-General, as it showed that Member States were committed to improving the current situation. The Working Group had held its first meeting in April 2011, in a spirit of cooperation that contrasted with previous discussions on the subject. It was to be hoped that the next meeting, to be held in October 2011, would produce recommendations for submission to the Board at its 130th session.

He trusted that Member States would avoid becoming embroiled in the political considerations that had led to a vote on a similar draft resolution at the Sixty-third World Health Assembly,[1] and he urged them to redouble their efforts to reach a consensus based solely on practical considerations and equity.

The CHAIRMAN said that that statement had been noted.

[1] Document WHA63/2010/REC/3, summary record of the first (section 6), third, fifth, sixth and seventh meetings of Committee B.

2. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Child injury prevention: Item 13.14 of the Agenda (Documents A64/23 and EB128/2011/REC/1, resolution EB129.R15)

Dr MOHAMED (representative of the Executive Board) said that the Executive Board, at its 128th session, had considered a report and a draft resolution on child injury prevention. He summarized the Board's discussion and proposed amendments that had led to the adoption of resolution EB128.R15, which recommended the Health Assembly to adopt the draft resolution contained therein.

Dr AL HAJERI (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed appreciation for WHO's work on a strategy on child injury prevention and endorsed the recommendations contained in the joint WHO/UNICEF *World report on child injury prevention*, particularly with regard to primary prevention. However, mainly for economic reasons, it was difficult for low- and middle-income countries to implement such a strategy. In the Region, many children living in poverty, who were particularly prone to injury, had limited access to health-care services. WHO had been an active contributor to the United Nations Secretary-General's Study on Violence against Children, which documented the many forms of violence to which children were subjected. It was important to differentiate between intentional and unintentional injuries and to take into account social, cultural and other factors in individual countries.

As child injury prevention involved many sectors of the Organization and other organizations in the United Nations system, intersectoral action was needed. Most interventions to prevent childhood injuries were made in developing countries, and WHO should invest more in capacity building and training at national and subnational levels and encourage countries to strengthen measures to prevent child injury. Such prevention should be mentioned specifically under the relevant Millennium Development Goal and accorded the same level of support as noncommunicable diseases. Measures taken to tackle child injury prevention should also be regularly evaluated. The number of injuries suffered by children under the age of 15 years had to be reduced. The Member States of the Region were committed to giving priority to child injury prevention activities in their health programmes and to allocating the necessary resources for their implementation. She supported the draft resolution and called on other Member States to adopt it.

Mrs MALTA (Brazil) commended the joint WHO/UNICEF *World report on child injury prevention*, but noted the need for recommendations on public policies and programmes and on strengthening health systems in order for the problem to be tackled effectively. Morbidity and mortality profiles for children and young people showed that most causes of child injury were external and therefore were a public health matter that should be dealt with by governments. Most deaths among children and young people were preventable, especially those caused by road traffic injuries which, in her country, were the main cause of death among children, followed by drowning, burns, falls and intoxication. Her Government had passed a law prohibiting drinking and driving that had reduced road traffic deaths and injuries. Legislation had also been enacted to regulate the use of seatbelts and child safety seats, and a mobile pre-hospital emergency system had been set up. Data on accidents and violence were regularly monitored. In addition to the health sector, various other sectors were involved in preventing child injury, including education, transport, law enforcement, environment and agriculture, so a multisectoral approach was needed. Since falls were a major cause of morbidity in children and mainly happened in the home, family-oriented health education and risk prevention should be promoted. She endorsed the draft resolution and encouraged Member States to adopt it.

Mr BROU (Côte d'Ivoire) pointed out that the increase in child injuries stemmed mainly from a rise in road traffic accidents, a failure to use child-restraint and protection devices, and violence, whether intentional or not. In 2001, a total of 6540 road traffic accidents, 34% involving pedestrians, had been recorded in Côte d'Ivoire, caused, in order of frequency, by: imprudence on the part of pedestrians, driver carelessness, excessive speed, loss of control, dangerous parking and mechanical failure. Therefore, his Government had decided to focus attention on children, within the context of noncommunicable diseases. He thanked WHO for its efforts to step up the campaign to prevent child injury.

Ms WAKEFIELD (United States of America) said that her Government was committed to reducing the burden of child injury and therefore endorsed the report's emphasis on the need to prioritize and fund child injury prevention through appropriate legislative, administrative, social and educational measures. It supported the recommendations for preventing and controlling child injury contained in the report as well as the recommendations and best practices outlined in the joint WHO/UNICEF *World report on child injury prevention.*

Child injury prevention should be integrated into public health and child survival programmes by collecting global data on the burden and cost of injury, and developing and implementing an action plan that included legislation, public education and greater emergency and rehabilitative capacity. There was a need for more investment in programme activities as well as for applied research in low- and middle-income countries where the child injury burden was the greatest. Reliable data were needed as data systems tended to underestimate the burden of injury by including only children who were treated in public health facilities. Injury prevention should be an integral part of countries' child and adolescent health plans. Children's health should be addressed through prevention policies and programmes and through improved trauma response, emergency and hospital care, and rehabilitation. Health ministries could help nongovernmental and research organizations to identify, implement and evaluate prevention programmes that targeted the most common causes of child injury.

She proposed two changes to the draft resolution: in the first line of subparagraph 1(2), the word "commitment" should be replaced by "the fulfilment of their obligations"; and at the beginning of subparagraph 1(6), the word "ensure" should be replaced by "assure" .

Dr BOKENGE (Democratic Republic of the Congo), speaking on behalf of the Member States of the African Region, said that, according to international statistics, the burden of child injury was highest in the African Region, where 95% of child deaths due to injury occurred. However, the inadequacy of country-level statistics in the Region partly explained why child injury was not seen as a public health problem and not always included in health policies and programmes. Injuries suffered by children undermined the progress being made towards achieving Millennium Development Goal 4 (Reduce child mortality). To counteract that trend, he recommended three actions. The Secretariat should increase its support to countries to enable them to conduct national studies to identify the magnitude of the problem and determine its underlying causes, and to implement multisectoral policies and programmes that prioritized basic prevention measures. Secondly, Member States should adopt a holistic approach to the prevention of children's health problems, bearing in mind the multisectoral nature of the causes of child injury. Thirdly, the Secretariat should provide Member States with an opportunity to share their experience and knowledge with a view to improving and consolidating national policies on child injury prevention. He encouraged all Member States to support the draft resolution.

Ms SHI Qi (China) said that a survey on the causes of child deaths conducted in China between 2004 and 2005 showed that injury accounted for 42.2% of deaths among children aged between 1 and 4 years, 58.8% of deaths among those aged between 5 and 9 years, and 51.1% of deaths among young people aged between 15 and 19 years. Her Government recognized that preventing child injury was a shared responsibility requiring multisectoral cooperation. WHO should therefore endeavour to

integrate child injury prevention into the public health agenda. Governments and national health departments should provide information on injuries internationally and nationally in order to enhance awareness in schools and among manufacturers of children's products, play area operators, and families. She endorsed the draft resolution.

Dr MANSOOR (Iraq) said that the prevention of child injury, an important factor in improving maternal and child health, should be included among the Millennium Development Goals. It was necessary to engage all stakeholders, including manufacturers of children's products and families, in raising awareness and promoting training, in order to ensure that children grew up in a safe environment. Children should also be taught to recognize danger and avoid injury. A strategy for dealing with emergencies, including administering first aid, should be developed and integrated in the school curriculum, and teachers and parents should be trained to act appropriately and in a timely manner. Children's playgrounds should be made safe and children trained to use playground equipment. The capacity of health-care professionals to diagnose child injuries also needed to be improved.

The prevention of child injury was an important element within the framework of the United Nations Decade of Action for Road Safety (2011–2020) and, with that in mind, he urged Member States to support the draft resolution.

Dr BRENNEN (Bahamas) supported the draft resolution. His Government recognized that deaths among children aged between one and four years contributed disproportionately to child mortality rates and that reducing those deaths was crucial for attaining Millennium Development Goal 4. The population of the Bahamas was small and its social and economic development depended on its young people. The loss of even a small number of that group could have a devastating long-term effect. Attention had been drawn to the issue of child injury prevention through improved public service announcements, lectures, health-care provider education and increased emphasis on enforcing laws on seatbelt and child safety-seat use. However, the WHO/UNICEF *Report on child injury prevention* had made it clear that the incorporation of other evidence-based initiatives for reducing child injury could lead to further programme improvement. The designation of a focal point within health ministries to provide health-sector and intersectoral leadership was of paramount importance. The active involvement of sectors such as education, transport, environment and law enforcement would be essential in defining and meeting country-specific needs and targets for reducing injury. His Government recognized the need for particular improvement in its provision of trauma and emergency care, and welcomed guidance from the Organization in that regard.

Mrs HANJAM SOARES (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, said that the WHO/UNICEF *Report on child injury prevention* urged countries to keep children safe by promoting evidence-based injury prevention interventions and sustained investment by all sectors. In the South-East Asia Region, injury was a major cause of death. In 2004, the Region recorded the second highest rate of unintentional child injuries. Road traffic injuries, drowning, burns and self-inflicted injuries were the leading causes of death among children. Despite the efforts of some Member States in the Region, many challenges remained, including the persistent belief that injuries were caused by fate, as well as difficulties in data gathering and programme implementation, limited human and financial resources and inadequate political commitment. Timor-Leste was committed to reducing child mortality and morbidity related to injury. She therefore supported the draft resolution and urged other Member States to do the same.

Dr SAIPIN HATHIRAT (Thailand) said that the WHO/UNICEF *Report on child injury prevention* confirmed that child injury was preventable through better public health and social policies; sustainable commitment; concerted intersectoral and intercountry efforts; citizen empowerment; and a proactive approach that involved tackling the root causes and determinants of the problem. Children everywhere were being increasingly exposed to risk, including heavy traffic, lack of

safe spaces and inadequate child-care facilities. There was also a contradiction between the increasing risk to which children were exposed and the fact that safety products for children, including safety helmets and safety seats, were either unavailable, unaffordable or of poor quality in low- and middle-income countries.

She proposed three amendments to the draft resolution. A new fifth preambular paragraph (bis) should be inserted to read: "Recognizing that the five leading causes of child unintentional injury deaths include road traffic injury, drowning, fire-related burns, falls and poisoning, particularly drowning, which is responsible for about half of total child injury deaths, context-specific preventive measures, including a safe environment, safety products, safety management and awareness raising are crucial". In the fourth line of subparagraph 1(7), the word "transportation" should be inserted between "spaces" and "construction". In line 2 of subparagraph 1(11), the words "as well as all members of society" should be inserted between "groups" and "about". She supported the draft resolution.

Mrs TZIMAS (Germany) said that unintentional injuries could be prevented by effective and simple interventions, including enforcing speed limits, especially near schools, residential areas and play areas; formulating and enforcing laws on drinking and driving; wearing bicycle and motorcycle helmets and using seatbelts; and setting up poison control centres. The prevention of child injuries was a multisectoral issue linked to the principle of health for all. Therefore, injury prevention programmes should be an integral part of children's health strategies. In the event of injury, it was essential that all necessary measures were taken to limit the long-term effects on children and their families. It would be helpful for data on child injury prevention to be collected and made available on the Internet. Additionally, national strategic goals had a positive effect and were well received by the public. For example, her Government had set a target of reducing accidents involving children by 20%.

She supported the draft resolution and called on Member States to take effective measures to prevent child injuries and death.

Mr PRASAD (India) concurred that child injuries were a major public health concern. About 30% of the Indian population was aged under 15 years: a group at high risk for injury. The nature of child injuries varied according to the stage of development; for example, road traffic injuries were common among schoolchildren and adolescents. Many children worked in jobs that exposed them to injury. Socioeconomic disadvantage was closely correlated with child injury, and its prevention was crucial to attaining Millennium Development Goal 4 (Reduce child mortality). Resources allocated to child injury prevention should be commensurate with the breadth of the problem. This was particularly the case in the South-East Asia Region, which would also benefit from the development of appropriate protocols and technical tools. Preventing childhood injuries required multisectoral coordination. The health sector could play a major role in child injury prevention, management and rehabilitation of the injured, and the development of injury prevention and control programmes by taking a number of steps: implementing appropriate emergency and pre-hospital care programmes; conducting trauma audits on the basis of minimum care guidelines; providing health-care delivery systems with adequate physical, technical and human resources; developing cost-effective, culture-specific and sustainable rehabilitation programmes; enhancing the skills of trauma-care professionals; and networking in order to develop an intersectoral approach. He endorsed the draft resolution.

Ms LAWLEY (Canada) said that the draft resolution was in line with her Government's commitment to child injury prevention. The principle of broadening the scope of data collection to include demographic, socioeconomic and economic factors was acceptable, but its practical application would depend on the resources available. The collection of basic injury data might be a more realistic first step in some settings.

She would be able to support the draft resolution with the following minor revision. In subparagraph 2(2), the text after "nongovernmental organizations" should be replaced to read: "to establish an effective network to ensure effective coordination and implementation of activities for

child injury prevention in low- and middle-income countries". The modified text placed emphasis on coordination and implementation of activities, instead of just information sharing. According to the report on the financial and administrative implications of the draft resolution,[1] there were insufficient funds to cover implementation costs fully over the next 10 years. Child injury prevention activities should therefore be prioritized so that some of them could be implemented while additional funding was being sought for those remaining.

Mr LAHLOU (Morocco) outlined the main causes responsible for the high level of child injuries and welcomed the draft resolution on child injury prevention. Any strategy to reduce the number of deaths from such injuries would require a multisectoral and multidisciplinary approach at several levels, including at school and in the home, that also took into account the cultural environment.

To prevent child injuries and limit their consequences, WHO should use promote the use of targeted research to expand existing knowledge with regard to interventions, and should assess such interventions in conjunction with its partners. Research outcomes could then be used to generate safe and affordable solutions. Technical assistance should also be provided for training health professionals in child emergency care and rehabilitation, and standards and criteria for those services needed to be defined, especially with regard to human resources.

Professor ARSLAN (Bangladesh) said that child injury was a national tragedy for Bangladesh. His Government was according priority to injury prevention programmes, taking new initiatives and strengthening existing programmes. With technical support from WHO and UNICEF, the Ministry of Health was preparing an injury prevention strategy, and priority was being given to child injury prevention activities in the next five-year health sector programme. Strengthening emergency medical services at national, district and subdistrict levels to improve management of injuries and injury-related disabilities was an existing priority. Bangladesh and other developing countries needed support in quantifying the economic impact of child injuries on families and the country as a whole, so that country-specific programmes could be devised. It was fostering coordination and collaboration among different sectors, including transport, health, law enforcement, education and environment, in order to achieve common injury prevention goals.

In Bangladesh, drowning was the major cause of injury-related mortality in children aged between one and four years. His Government had pioneered the development of simple, cost-effective drowning prevention techniques, and would share its experience and substantial research findings with countries facing similar problems. Burn injuries had also increased, but his country had yet to devise interventions to prevent them. WHO could play a key role in disseminating the experience of countries with successful programmes for preventing burn injuries in order to help other countries to develop similar programmes. More research into cost-effective, sustainable measures to prevent child injury, and increased investment in building institutional and individual capacity were required so that countries could develop appropriate interventions at national and regional level. He welcomed the draft resolution.

Mr JAZAÏRY (Algeria) endorsed the recommendations proposed by the delegate of the Democratic Republic of the Congo, as they would make the draft resolution more effective. He also welcomed the amendments proposed by the delegate of the United States, particularly the proposed amendment to subparagraph 1(2), which emphasized the fulfilment of Member States' obligations under the Convention on the Rights of the Child. He took that emphasis as a sign that the United States, which was the only country in the world not to have ratified the Convention, would do so in the near future.

[1] See document EB128/2011/REC/1, Annex 4.

Mr MANDABA (Central African Republic) said that unintentional injury to children was a major public health problem in his country as it was the main cause of child disability and death. In line with his Government's obligations under the Convention on the Rights of the Child and its commitment to achieving the Millennium Development Goals, child injury prevention had been placed at the centre of all its efforts to reduce child mortality and morbidity rates, including a programme devised by the health ministry to improve children's overall well-being. Despite progress having been made, significant challenges remained, mainly because of the shortage of human and financial resources and biomedical equipment, the absence of prevention programmes and emergency care services, and lax enforcement of child protection laws. Child injury prevention and care programmes needed to be set up, and measures taken to strengthen the health workforce and stem the exodus of health professionals. Technical capacity should be reinforced and the relevant laws rigorously applied, particularly those on child neglect, and drinking and driving. Emphasis should also be placed on helping children avoid injury by changing their behaviour.

He renewed his Government's request to the international community, and the Secretariat in particular, to support his country's efforts to control the scourge of childhood injury.

Dr KOSHY (Malaysia) recognized the need to prevent road traffic injuries, which were the main cause of injury in children aged between 12 and 19 years. Her Government had established a road safety department with a research section, within the Ministry of Transport, and had launched, with full participation of the Ministry of Health, a multisectoral road safety action plan, one priority of which was road safety education in schools. She endorsed the draft resolution.

Ms BENNETT (Australia) urged Member States to take specific measures to reduce injuries to children. Significant advances had been made in her own country through a range of programmes, particularly on water safety and road safety. She endorsed the draft resolution and supported the amendment to subparagraph 2(2) proposed by the delegate of Canada.

Dr SAIPIN HATHIRAT (Thailand) proposed a minor change to the new preambular paragraph it had previously proposed. The fifth preambular paragraph bis should instead read: "Recognizing that the leading causes of child deaths from unintentional injury include road traffic injury, drowning, fire-related burns, falls and poisoning. In some regions of the world drowning is responsible for about half of total child injury deaths, context-specific preventive measures, including a safe environment, safety products, safety management and awareness raising are crucial".

Dr Shin-Lan KOONG (Chinese Taipei) said that in Chinese Taipei the mandatory use of motorcycle helmets and child safety seats together with intersectoral efforts to improve child safety in the home, at school and during leisure hours had proved successful in reducing child injuries, which had dropped from 30 per 100 000 to 11 per 100 000 in the past 10 years. It was important to introduce child injury prevention strategies into existing child health services programmes. Injury prevention training was provided to parents and a household injury prevention checklist and a health education pamphlet had been issued to assist them in creating a safe home environment. Communities and schools were also being helped to reduce potential risks and improve safety.

Sound surveillance systems were vital to devising effective strategies for preventing child injury, and information from various sources, including a survey of adolescent behaviour and a health insurance database, was regularly monitored. Having developed a comprehensive child injury prevention system encompassing regulation, policy, health promotion, and a health-care network, Chinese Taipei would welcome the opportunity to share its experience and skills with Member States. She endorsed the draft resolution.

Dr ALWAN (Assistant Director-General) thanked Member States for their valuable contributions and for endorsing the draft resolution. The recommendations and requests would be

taken into account. He looked forward to working closely with Member States in implementing the draft resolution once it had been adopted. In response to a question from the delegate of India concerning new tools, he said that a document describing successful interventions for preventing burns would be issued that week.

The CHAIRMAN said that the Secretariat would prepare and circulate a revised version of the draft resolution containing all the proposed amendments.

It was so agreed.

(For approval of the draft resolution, see the summary record of the sixth meeting, section 2.)

Strategies for the safe management of drinking-water for human consumption: Item 13.15 of the Agenda (Document A64/24)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Andorra, Armenia, Austria, Belgium, Brazil, Colombia, Denmark, Finland, France, Germany, Hungary, Italy, Japan, Monaco, Morocco, Netherlands, Portugal, Senegal, Slovenia, Spain, Switzerland and Yemen, which read:

The Sixty-fourth World Health Assembly,

PP1 Having considered the report on strategies for the safe management of drinking-water for human consumption;[1]

PP2 Recalling the Declaration of Alma-Ata on Primary Health Care and the various resolutions stressing the role of improving safe drinking-water, sanitation facilities and hygiene practices in primary health care, environmental health, prevention of waterborne diseases, protection of high risk communities, infant and young child nutrition, including resolutions WHA39.20, WHA42.25, WHA44.28, WHA45.31, WHA35.17, WHA51.28 and WHA63.23, as well as resolutions EB128.R7 and EB128.R6 containing respectively draft resolutions on cholera: mechanisms for control and prevention, and on eradication of dracunculiasis;

PP3 Recalling further target C of Goal 7 (Ensure environmental sustainability) of the Millennium Development Goals, which calls for reducing by half the proportion of the population without sustainable access to safe drinking-water and basic sanitation by 2015, and the importance of this target for the achievement of other Goals, particularly Goals 4 (Reduce child mortality), 5 (Improve maternal health) and 6 (Combat HIV/AIDS, malaria and other diseases);[2]

PP4 Recognizing that between 1990 and 2008 an estimated 1.77 billion people gained access to improved sources of drinking-water and 1.26 billion gained access to improved sanitation, but deeply concerned that by the end of 2008 884 million people still lacked access to improved water sources and over 2.6 billion people did not have access to improved sanitation;

PP5 Noting the multiple health benefits and economic advantages of a broad public health approach through the expansion of access to safe drinking-water and sanitation, integrating household

[1] Document A64/24.

[2] See United Nations General Assembly document A/65/L.1.

interventions, a more effective use of resources and the early incorporation of health considerations in the planning and design of water resources development, and recognizing the importance of pursuing these issues for the achievement of strategic objective 8 of the Medium-term strategic plan 2008–2013;

PP6 Recalling the International Decade for Action, "Water for Life" 2005–2015, proclaimed by the United Nations General Assembly in resolution 58/217; the International Year of Sanitation, 2008, declared in resolution 61/192; as well as the follow-up resolution 65/153, calling upon all Member States to support the global effort to realize "Sustainable sanitation: the five-year-drive to 2015"; and also recalling that water quality was the theme of the United Nations World Water Day 2010;

PP7 Recalling further the United Nations General Assembly resolution 64/292, which recognizes the right to safe and clean drinking-water and sanitation as a "human right that is essential for the full enjoyment of life and all human rights" and the Human Rights Council resolution (A/HRC/RES/15/9) affirming that the "human right to safe drinking water and sanitation is derived from the right to an adequate standard of living and inextricably related to the right to the highest attainable standard of physical and mental health, as well as the right to life and human dignity";

PP8 Noting with interest the efforts made to improve access to safe drinking-water, basic sanitation and to promote good personal and domestic hygiene practices that contribute to a sustainable approach to fight sanitation- and water-related diseases such as cholera and diarrhoea, which claimed the lives of 2.5 million people in 2008, among which 1.3 million children under the age of five;

PP9 Also noting the water, sanitation and hygiene components in the seven-point strategy agreed by WHO and UNICEF for comprehensive diarrhoea control, which include the promotion of hand washing with soap, household water treatment and safe storage and community-wide sanitation promotion;

PP10 Noting that millions of people are exposed to dangerous levels of biological contaminants and chemical pollutants in their drinking-water partly due to inadequate management of urban, industrial or agricultural wastewater;

PP11 Recognizing WHO's major normative role in issues of water and health, its key role in monitoring progress regarding water supply and sanitation as well as its promotional and capacity-building roles for Water Safety Plans, Sanitation Safety Plans, water and sanitation in health care, schools and other public buildings and settings, and safe management of medical waste;

PP12 Noting that global driving forces, including population growth, urbanization and climate change, are expected to affect significantly the availability and quality of access to water and sanitation services and of freshwater resources and the need for water resources development for other purposes, which in themselves carry potential health risks, and noting that a response to these trends requires an intersectoral approach mainstreaming health and environmental issues in national sectoral policies through integrated water resources management and strengthened institutional arrangements to prevent and reduce the incidence of sanitation- and water-related diseases;

PP13 Noting that over the last decade almost two billion people were victims of natural disasters, including floods and droughts, that act as key contributors to sanitation- and water-related diseases; also recognizing the need, in emergency situations, to develop prevention tools and specific actions for supplying drinking-water and sanitation as well as the leading role of both WHO in the

Health cluster and UNICEF in the Nutrition and WASH (Water, Sanitation and Hygiene) clusters in emergency operations,

1. URGES Member States:

(1) to develop and strengthen, with all stakeholders, national public health strategies, so that they highlight the importance of safe drinking-water, sanitation and hygiene as the basis for primary prevention, based on an integrated approach of sectoral planning processes, policies, programmes and projects regarding water and sanitation, guided by an effective interministerial coordination mechanism at appropriate level, designating clear responsibilities across relevant ministries and institutions;

(2) to promote new approaches to community education and awareness creation involving actively their leaders and civil society, with a view to having a specific impact, particularly on women, children, youth, indigenous people and vulnerable and marginalized people, acknowledging and encouraging good practices;

(3) to ensure that national health strategies contribute to the realization of water- and sanitation-related Millennium Development Goals while coming in support to the progressive realization of the human right to water and sanitation that entitles everyone, without discrimination, to water and sanitation that is sufficient, safe, acceptable, physically accessible and affordable for personal and domestic uses;

(4) to strengthen the intersectoral policy frameworks and institutional mechanisms for integrated management of water- and sanitation-related health hazards and risks, including health impact assessment, strategic extension of drinking-water and sanitation systems and services, and environmental management to protect health in water resources and wastewater management projects;

(5) to mobilize their efforts, in consultation with bilateral and multilateral partners and in close coordination with responsible local authorities, to prioritize the reduction of disparities which exist between urban, peri-urban and rural areas as regards access to drinking-water at home as well as from other improved sources, improved sanitation facilities and hygiene;

(6) to offer appropriate facilities for access to safe drinking-water, sanitation and hand washing with soap in health care establishments, schools and other public buildings and settings, as well as advocacy and training tools on safe water, sanitation and hygiene practices for those who operate and use these establishments;

(7) to improve cooperation between the appropriate authorities and stakeholders, including in transboundary settings, to establish, implement and maintain efficient systems for assessing water quality, regularly communicating relevant, easily accessible information and responding to water quality issues;

(8) to ensure, in particular, the sustainability of comprehensive and harmonized national and/or local water and sanitation- related monitoring systems and early warning tools in order to prevent and control sanitation- and water-related diseases as well as to develop emergency preparedness and action plans, particularly in case of natural disasters and humanitarian emergencies;

(9) to work to strengthen, as necessary, the establishment, implementation and quality control of water safety plans and contribute to the development of sanitation safety plans, in

collaboration with the WHO collaborating centres, WHO-hosted networks (drinking-water regulators, operation and maintenance, household water treatment and safe storage, management of small-community water supplies) and associations in official relations with WHO;

2. REQUESTS the Director-General:

(1) to continue calling the attention of the international community and decision-makers to the importance of primary prevention as a key goal, and the major impact of safe drinking-water, sanitation and hygiene on global public health, national economies, and the achievement of the Millennium Development Goals;

(2) to formulate a new, integrated WHO strategy for water, sanitation and health including a specific focus on water quality and monitoring issues, and on promotion of sanitation and hygiene behaviour change taking into account context-specific requirements with a view to encouraging the establishment of preventative measures as well as rapid analysis techniques to guarantee the quality of drinking-water and avoid adverse health impacts of water resources development;

(3) to strengthen WHO's collaboration with all relevant UN-Water members and partners, as well as other relevant organizations promoting access to safe drinking-water, sanitation and hygiene services, so as to set an example of effective intersectoral action in the context of WHO's involvement in the United Nations Delivering as One initiative, and WHO's cooperation with the United Nations Special Rapporteur on the human right to safe drinking water and sanitation with a view to improving the progressive realization of the human right to water and sanitation;

(4) to strengthen the WHO/UNICEF Joint Monitoring Programme capacities to fulfil its mandate of monitoring progress towards the international drinking-water and sanitation development goals, and to serve as a platform for a generation of new sanitation and water indicators, including water quality and other relevant parameters at appropriate levels;

(5) to continue supporting existing regional initiatives such as the United Nations Economic Commission for Europe's Protocol on Water and Health which is an instrument of reference for safe water management and the protection of human health and encourage the creation of similar instruments dedicated to sustainable water management and reduction of sanitation- and water-related diseases in other regions, as well as continue to encourage relevant regional initiatives such as the WHO/UNEP Libreville Declaration on Health and Environment (2010) or the WHO Parma Declaration on Environment and Health (2010);

(6) to develop, in coordination with bilateral and multilateral partners, Member States' capacities by providing guidelines and technical support to develop, implement, monitor and evaluate national action plans for the sustainable management, operation and maintenance of safe drinking-water supply and sanitation systems and services;

(7) to further support Member States' capacities in building and maintaining adapted information and monitoring systems in order to facilitate the appropriate and streamlined reporting to relevant global monitoring mechanisms including the WHO World Health Statistics, the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation and the UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water;

(8) to increase technical assistance to countries by facilitating training and adult learning programmes for staff in charge of maintaining catchments, treatment and distribution facilities, water and sanitation networks and for staff and laboratories in charge of water quality monitoring, while encouraging the dissemination of best practices for household water treatment, especially where central water treatment or water supplies are deficient or not available;

(9) to promote partnerships for risk reduction in drinking-water installations and safe supply of drinking-water and methods to gather and disseminate the best practices and experiences in increasing access to safe drinking-water, sanitation and personal and domestic hygiene, in particular for the poorest populations, in health emergencies or during natural disasters;

(10) to report on progress in implementing this resolution, through the Executive Board, to the Sixty-sixth World Health Assembly.

The financial and administrative implications for the Secretariat of the draft resolution were:

1. Resolution Drinking-water, sanitation and health

2. Linkage to programme budget

Strategic objective:	Organization-wide expected result:
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.	8.1 Evidence-based assessments made, and norms and standards formulated and updated on major environmental hazards to health (e.g., poor air quality, chemical substances, electromagnetic fields, radon, poor-quality drinking-water and wastewater reuse). 8.2 Technical support and guidance provided to Member States for the implementation of primary prevention interventions that reduce environmental hazards to health, enhance safety and promote public health, including in specific settings (e.g. workplaces, homes or urban settings) and among vulnerable population groups (e.g. children). 8.4 Guidance, tools and initiatives created in order to support the health sector in influencing policies in other sectors to allow policies that improve health, the environment and safety to be identified and adopted. 8.5 Health-sector leadership enhanced for creating a healthier environment and changing policies in all sectors so as to tackle the root causes of environmental threats to health, through means such as responding to emerging and re-emerging consequences of development on environmental health and altered patterns of consumption and production and to the damaging effect of evolving technologies.

(Briefly indicate the linkage with expected results, indicators, targets, baseline)

Drinking-water, sanitation and health issues cut across the Organization-wide expected results for strategic objective 8, particularly 8.1 (risk assessment and management guidelines), 8.2 (primary prevention), 8.4 (intersectoral capacity-building) and 8.5 (monitoring). Strengthened work on the

prevention of water- and sanitation-related disease is consistent with the expected results under the strategic objective, and implementation of the resolution would be reflected within the indicators and targets of expected results mentioned above.

3. Budgetary implications

(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US$ 10 000, including staff and activities).

In addition to the current programme, the estimated cost for the period 2012–2013 is US$ 3.94 million. The estimated cost per biennium on a continuing basis thereafter is about US$ 21 million.

(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).

US$ 985 000 (25% of US$ 3.94 million for the last six months of the biennium).

Costs will be incurred at headquarters and at the regional office level in those offices currently lacking advisors who specialize in water, sanitation and health, namely, the regional offices for Africa, the Eastern Mediterranean and the Western Pacific.

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

No.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Additional voluntary funds are being sought; a number of parties have indicated interest.

5. Administrative implications

(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).

Implementation will involve activities at global, regional and country levels. Headquarters will play a coordination and management role and provide guidance and standard-setting, and will support the implementation of activities.

The regional offices will support the work in monitoring, water-safety planning, capacity building and approaches in specific settings.

Projects with a strong country focus will require the involvement of country office staff for satisfactory implementation.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No.

(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).

The following additional staff will be required: a Monitoring Manager at grade P.5; a Technical Officer at grade P.3 to support UN-Water's Global Analysis and Assessment of Sanitation and Drinking-Water; two Technical Officers at grade P.4, one to deal specifically with wastewater activities, and the other to deal with national health strategies to influence realization of the basic human right to water and sanitation; and three Regional Advisors on water, sanitation and health at grade P.4 (one in each of the regional offices for Africa, the Eastern Mediterranean and the Western Pacific).

(d) Time frames (indicate broad time frames for implementation of activities).

2010–2011. Following a broad consultation on developing a new generation of targets and indicators for post-2015 water and sanitation monitoring, a number of working groups will be activated as of 1 July 2011, with an incremental increase of staff to meet additional work requirements.

2012–2013. The start-up phase and coordination of strategic work should be completed; thereafter implementation of activities will be on a continuing basis.

Mr PELLET (France) said that the draft resolution, largely inspired by the Secretariat's report on the same subject, had been prepared by a working group composed of representatives of Member States from all WHO's regions, namely, Colombia, Hungary, Japan, Morocco, Senegal, Switzerland and Yemen. According to WHO statistics, 884 million people still did not have access to safe drinking-water and 2600 million people lacked basic sanitation. Safe drinking-water and access to basic sanitation were central to achieving Millennium Development Goal 7 (Ensure environmental sustainability), and a necessary condition for achieving Goal 4 (Reduce child mortality), Goal 5 (Improve maternal health) and Goal 6 (Combat HIV/AIDS, malaria and other diseases). Moreover, the right to safe drinking-water and sanitation had been recognized by the United Nations as being necessary for better physical and mental health, two essential components of the right to life and human dignity. The international community had to redouble its efforts to reach the Millennium Development Goals. In particular, the Secretariat needed to give fresh impetus to water-management activities and encourage Member States to do the same.

The draft resolution was the fruit of discussions at both the 127th and 128th sessions of the Executive Board, and broad consultations. Following meetings held in January and April 2011 to which all Member States had been invited, and the dissemination of the draft to stakeholders, many valuable contributions from both Member States and nongovernmental organizations had been integrated into the draft resolution.

The draft resolution set out three main areas of work for WHO, namely governance and the role of health authorities, promotion of operational approaches based on best practices, and primary prevention. Within that framework, it outlined an integrated strategy for ensuring access to safe drinking-water and improved sanitation; promoting best practices in the area of hygiene; reducing the transmission of waterborne infections; and fostering institutional cooperation and a multidisciplinary approach.

The following Member States also wished to sponsor the draft resolution: Côte d'Ivoire, Norway, Republic of Moldova and Uruguay. All the sponsors wanted the draft resolution to be adopted by consensus as it pursued a commonly shared goal and complemented two other draft resolutions to be considered by the Health Assembly, namely those in resolution EB128.R3 (Cholera: mechanism for control and prevention) and resolution EB128.R6 (Eradication of dracunculiasis). It also formed part of the collective effort to meet the challenges of water management, one important aspect of which would be the Sixth World Water Forum due to be held in Marseille, France on 12–17 March 2012.

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region, said that improving access to safe drinking-water was a top priority for the African Region as the lack of that access was central to most public health problems. Many deaths among poor people in shanty towns and rural areas were caused by a lack of safe drinking-water. Inadequate or non-existent sanitation, combined with the lack of safe drinking-water, was frequently the cause of lethal epidemics, including major cholera outbreaks, that devastated people's lives. In sub-Saharan Africa, an average of 60% of the population had had access to improved drinking-water in 2008, but safe drinking-water coverage was not keeping pace with rapid demographic growth and urbanization. In many countries the conditions in which water was transported and stored reduced its quality.

Some countries in the Region had made progress, notably in implementing programmes that had increased access to safe drinking-water in urban areas. Governments in the Region were strongly committed to improving the quality of drinking-water and sanitation. Three countries had implemented safe drinking-water programmes, and four had adopted health frameworks to deal with health and environment problems.

The African Region was committed to evaluating national health and environmental priorities, in particular with reference to safe drinking-water. It was also collaborating with the International Network of Drinking-water Regulators to help countries to regulate the quality of drinking-water. It appreciated WHO's work on developing and field testing technologies for hand washing, household water treatment and safe water storage, and the Organization's support under the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation.

Limited access to safe drinking-water was an obstacle to reducing poverty, hunger and infant mortality, improving maternal health and controlling illness. A multisectoral approach to drinking-water, under the leadership of health ministers, was therefore indispensable and he called on the international community to support African governments in their efforts to that end.

He urged Member States to support the draft resolution.

Dr SAKAMOTO (Japan) said that it was a matter for regret that many people were still obliged to drink unsafe water, given its association with disease and poverty. Her country had been contributing its knowledge and technology to efforts to improve water quality and sanitation, in particular by promoting broad partnerships and through its work in the African Region, and was committed to advocating for that issue in international forums.

Water resources fit for human usage were scarce, a problem that was set to grow in importance owing to population growth, increases in food production, economic growth, urbanization, improvements in standards of living, and climate change. Discussion of the present resolution was likely to raise awareness of the scale of the problem.

The Secretariat had been advising Member States on water-quality management through its guidelines for drinking-water quality, based on the latest scientific advances in risk assessment and management. It should give consideration to drawing up a new water-quality strategy, covering drinking-water, wastewater and recreation, and should regularly update its guidelines.

Mr AL KEHALY (Yemen), endorsing the statement by the delegate of France, noted that 60% of the population in most third world countries did not have access to drinking-water owing to severe shortages. Poor-quality drinking-water had been responsible for a widespread outbreak of diarrhoea in Yemen a few years previously. In response to an appeal from the country's health ministry, WHO had agreed to meet the affected population's basic development needs and a US$ 10 000 plan had been implemented to sanitize, provide drinking-water to, and construct water-storage cisterns in seven regions.

He called on the Secretariat to support and encourage efforts to identify health determinants. He endorsed the draft resolution, and urged other Member States to do so.

Mr ROSALES LOZADA (Plurinational State of Bolivia) placed the utmost importance on drinking-water, sanitation and health. The "water war" of February 2000, in which Bolivian villagers had combated a water privatization plan, had sparked a series of actions demonstrating the importance of access to water, for the well-being of the population as well as for human life. His country, for example, had sponsored resolution 64/292, adopted in August 2010 by the United Nations General Assembly, which recognized access to water and sanitation as human rights. The right to water, which was an essential right on its own, and the right to health were mutually complementary and intrinsically linked. He welcomed the draft resolution, which not only reinforced that link but also gave timely impetus to WHO's activities in that area.

He proposed that, in the seventh preambular paragraph, only the reference to the United Nations General Assembly resolution be kept, as it was contradictory to refer to the rights to water and sanitation both as rights in themselves and as derived rights. In subparagraph 1(2), the word "marginalized", which was unclear, should be replaced by "the poorest". In subparagraphs 1(3) and 2(3), "progressive" should be deleted. He expressed the hope that those amendments, and the draft resolution as a whole, would be accepted by consensus.

Ms HELFER-VOGEL (Colombia) said that lack of access to water, sanitation and hygiene negatively affected people's health, safety, means of subsistence and quality of life. Despite the progress made, suggested by the significant increase in access to improved sources of drinking-water, millions still lacked access to such sources and to basic sanitation. Guaranteeing water and sanitation for all remained a global priority.

In her country, the ministries of social protection and the environment were working together on a public health policy that emphasized the importance of water quality. Nevertheless, much remained to be done to ensure the provision of drinking-water in remote, rural areas, and national environmental sanitation coverage.

An integrated approach to water, sanitation and hygiene would ensure that all countries met the Millennium Development Goals. Mortality and disease rates could be reduced by ensuring access to drinking-water and by fostering healthy environments in homes, schools, and workplaces. Ensuring access for all to drinking-water, basic sanitation and a healthy environment would help to improve quality of life, promote development and reduce costs related to pollution, environmental damage and illness. The availability of sufficient, safe and accessible drinking-water should be part of development plans and remain on the international agenda. She endorsed the draft resolution and expressed the hope that it would be approved by consensus.

Mr BROU (Côte d'Ivoire) affirmed the relevance of the Secretariat's report for the development of national policies on integrated management of water resources and environmental health. Implementation of the strategies put forward in the report would not only reduce the burden of sanitation- and water-related morbidity and mortality, but would also improve the well-being of people within the framework of sustainable development.

Mr TOSCANO VELASCO (Mexico) supported the draft resolution as his Government regarded the right to drinking-water and sanitation as fundamental for all countries. Mexico recognized access to drinking-water and sanitation as part of the human right to an adequate standard of living and the right to the enjoyment of the highest attainable standard of physical and mental health, as set forth in Article 25 of the Universal Declaration of Human Rights and Articles 11 and 12 of the International Covenant on Economic, Social and Cultural Rights. It interpreted subparagraph 1(3) of the draft resolution in that light.

Mexico would continue making all necessary efforts to adopt progressive measures, up to the limits of its available resources, to supply drinking-water and sanitation, as stipulated in its national legislation, to that part of its population that did not yet enjoy such services, in fulfillment of its international obligations and in line with the requirements of the Millennium Development Goals. The Constitution regulated ownership of the land and water lying within the limits of the national territory. His Government considered that equitable access to drinking-water and to basic sanitation should be guided by a national standard-setting framework. The draft resolution had therefore to be implemented in each country in line with its applicable legislation.

Mexico also considered that debate on the topic should be pursued in a constructive spirit within the framework established by the Human Rights Council.

Mrs TZIMAS (Germany) emphasized the importance in the developing world of access to safe drinking-water, and of sanitation and personal and domestic hygiene, along with awareness of health conditions. National health strategies should adequately reflect the burden posed by water-related

diseases and the value for health of safe water and sanitation. Greater intersectoral cooperation was needed, especially between the health and water sectors, to boost efficiency and impact. Water and sanitation programmes should aim to raise awareness and provide hygiene education to induce behavioural change, while health programmes should focus more on education about water-borne diseases, promoting change in hygiene practices and creating demand for sanitation. Between 2008 and 2010, her country had spent about US$ 900 million annually in development cooperation assistance relating to water and sanitation, and in particular to measures to control their impact on health. Such measures should be monitored more closely, with a view to ensuring a more systematic inclusion of water, sanitation and hygiene measures in health programmes, and hygiene and awareness-raising measures in water programmes.

She reaffirmed her country's support for the human right to safe drinking-water and sanitation.

Dr MANSOOR (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that water was becoming increasingly scarce in the Region; shortages were often the root cause of disease and insecurity, particularly in rural areas in low-income countries. Not having access to water made it impossible for people to meet even their basic needs in terms of hygiene. Even where water was available, sanitation tended to be inadequate. In order to attain the Millennium Development Goals people had to be aware of the need to conserve and manage water resources, and of the benefits to health of constructing wells rather than using groundwater. The WHO *Guidelines for drinking-water quality* needed revision and supplementing where necessary. A regional drinking-water strategy was needed that encompassed regulation and legislation and whose preparation included contributions from all relevant stakeholders. In Iraq, drinking-water was the key to public health. A lack of safe drinking-water had led people to use grey water that was meant for agriculture and was not fit for human consumption; measures to ensure proper use of wastewater were therefore needed.

Mr LINDGREN (Norway) said that, by improving the quality of water supplies, access to safe water, sanitation facilities and hygiene, the incidence of many diseases could be reduced. Water and sanitation were linked to the health-related Millennium Development Goals, and he recalled Human Rights Council resolution 15/9 on human rights and access to safe drinking water and sanitation, adopted in 2010. Achieving the Goals required a holistic approach, the responsibility for which lay with governments. WHO's leadership in the areas of safe drinking-water, basic sanitation and hygiene could further accelerate progress in that regard.

WHO was a driving force behind efforts to improve access to safe, clean water and to promote hygiene. He called on the European States to support the work being done jointly by WHO and the United Nations Economic Commission for Europe, under the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes. Setting national targets in accordance with Article 6 of the Protocol was particularly important. Given that nearly 140 million people in Europe still lived in homes unconnected to a safe drinking-water supply, the actions set out in the draft resolution would require a firm commitment for many years.

Professor ARSLAN (Bangladesh) emphasized water quality management, especially given the rapid urbanization in developing countries. It would be of benefit to both parties if countries in similar circumstances could share their experience and collaborate on developing practical and affordable interventions to raise water quality.

Bangladesh had made significant improvements in its response to natural disasters and emergencies through better management of water systems. However, for vulnerable countries like his, support from developed countries in reducing the adverse impact of climate change on water availability and water quality would be essential.

The draft resolution, which he endorsed, and that on the prevention and control of cholera, to be considered later by the Health Assembly, were complementary and mutually reinforcing. Together

they would mark a significant step forwards in managing drinking-water quality and promoting hygiene and sanitation.

Dr GULLY (Canada) supported the draft resolution. His country was among those with the safest drinking-water in the world and had an effective governance model, with shared responsibility among national, subnational and local levels of government. However, it was still facing challenges in small, rural and remote communities.

Canada had provided 410 million Canadian dollars in assistance to the water and sanitation sector in developing countries, of which more than two thirds had gone to improve drinking-water supply and sanitation services, particularly for women, children and other vulnerable groups in rural areas.

He asked whether the "new, integrated WHO strategy for water, sanitation and health" mentioned in subparagraph 2(2) of the draft resolution would be separate from, or inclusive of, the initiatives outlined in subparagraphs 2(3) to 2(9).

Implementation of the draft resolution would put significant additional financial pressure on WHO. In view of the Organization's current financial situation, he asked the Secretariat to specify which activities could be carried out with existing funds and which would require additional funding, and to give priority to activities that would achieve maximum results with minimal costs.

Dr NIPUNPORN VORAMONGKOL (Thailand), speaking on behalf of the Member States of the South-East Asia Region, welcomed delegates' contributions to the draft resolution. She fully agreed that safe drinking-water could not be considered in isolation from other issues, especially from sanitation, water pollution and chemical contamination. She proposed that in subparagraph 1(2), the words "empowerment, participation" should be inserted, following a comma, after "education". In subparagraph 1(5), the words "and implement" should be inserted after "prioritize".

Mr ZHAO Yuechao (China) said that the text would help Member States to strengthen their water management programmes. Access to drinking-water of sufficient quality and quantity was a crucial determinant of health, and formed part of several of the Millennium Development Goals. His country attached great importance to the safety of drinking-water and had taken increasingly more stringent measures in that regard, revising water-quality standards, boosting monitoring and surveillance networks, and improving drinking-water management through reform of the national health system. He looked forward to further opportunities to share his country's knowledge and experience on the global platform, and urged the Secretariat to provide greater guidance on risk assessments and improving the efficiency of water-safety management.

Mr WAHABI (Morocco) thanked the Secretariat for its efforts in the field of water, sanitation and health, which had helped Member States to improve their drinking-water standards and supply. Water-supply and sanitation facilities were of such importance that they should be considered as primary health services and be adequately funded, and national water-safety plans should be put in place.

The draft resolution laid the groundwork for a global strategy on water and sanitation, for which the report by the Secretariat provided all the necessary elements.

Mr CROTTAZ (Switzerland) affirmed that drinking-water provision, basic sanitation and sound resource-management were crucial to preventing water-borne diseases and protecting consumer health. The recent outbreaks of cholera in Haiti and Zimbabwe had been caused mainly by a lack of, or deterioration in the management of, sanitation facilities. Water and sanitation interventions should be focused and generate direct, measurable and sustainable results. His country's development aid had concentrated on water and health.

Member States must implement national strategies to improve hygiene through drinking-water usage and management, and run campaigns to sensitize and involve local communities, in particular in

the remotest regions. Existing regional initiatives, in particular the Protocol on Water and Health, administered jointly by WHO and the United Nations Economic Commission for Europe, should be supported as potential models for improving access to drinking-water and sanitation. On a global level, the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation was doing remarkable work in the area of promotion and political dialogue and should be given the resources it needed. He invited WHO to strengthen its cooperation with all United Nations bodies active in the water sector and expressed his support for the draft resolution.

Dr KARAGULOVA (Kazakhstan) expressed strong support for the draft resolution, affirming that access to safe drinking-water was a global issue of the utmost importance. She welcomed the inclusion in the draft of the proposed amendment submitted by her country three weeks previously, namely the insertion, in the second preambular paragraph, of the words “Recalling the Declaration of Alma-Ata on Primary Health Care”. That proposal had been based on the reference in the Declaration to “an adequate supply of safe water and basic sanitation” as one of the eight essential elements of primary health care. She asked for her country to be included as a sponsor.

Dr McMILLAN (Bahamas) supported the draft resolution. Her country was trying to improve water quality in a sustainable manner, through modern technology, improved water-management programmes, public-private partnerships and the renovation of its water infrastructure. Nevertheless, the challenge remained of developing a comprehensive water-safety plan to encompass all the archipelago’s inhabited islands. Reform of the regulatory and legal framework, better use of human resources, new monitoring and evaluation tools, and a water-resource management plan – spanning the health, agriculture, energy and environment sectors – had helped to achieve nearly universal access to safe drinking-water and sanitation throughout the country, in line with Millennium Development Goals 7 and 10.

Dr AL HAJERI (Bahrain) said that Bahrain needed to develop a strategy on the safe management of drinking-water in conformity with international standards and to introduce laboratory testing of water. Public awareness should be raised about the importance of protecting water resources from pollution. She supported the draft resolution.

Ms GIBB (United States of America) said that her Government remained deeply committed to finding solutions to the world’s water, sanitation and hygiene challenges. Governments and development partners had joined forces between 1990 and 2008, resulting in marked gains in access to improved sources of drinking-water, basic sanitation and hygiene. Significant work remained to be done, however. Member States must continue expanding their activities to ensure access to and effective maintenance of those essential systems, and strive to keep increased access to water, sanitation and hygiene high on the political and development agenda.

She drew attention to the need for precision in use of language. The report used a wide variety of terms to refer to water. In the interests of clarity, it would be helpful to use consistent terminology that stressed the difference between "clean” water, which generally referred to lake and river water, and "safe" water, which generally referred to water for drinking and other human consumption.

WHO might consider coordinating its activities with FAO, UNEP and the United Nations Forum on Sustainability Standards in order to develop an integrated strategy that acknowledged the linkages between water, food and climate.

Mr JAZAÏRY (Algeria) said that his country had been one of the first to enshrine in law the right to water and sanitation, through legislation enacted in 2005. A ministerial department was responsible for national policy on water resources and a regulatory authority had been created to monitor the quality and cost of water supply services. The rate of connection to the drinking-water supply network had risen from 78% in 1999 to 93% at present, and the rate of connection to the

sewerage system had risen from 72% to 86% in the same period. Thus Algeria had already surpassed Targets 7.C of Millennium Development Goal 7 (Ensure environmental sustainability). It had an installed wastewater treatment capacity of 800 million cubic metres per year, and the daily average supply of water per inhabitant had increased from 123 litres in 1999 to 168 litres at present, thereby making it a leader among developing countries in the distribution of drinking-water and sanitation.

Apparently a breakdown in communication had caused Algeria to be omitted from the list of sponsors of the draft resolution, but it joined those who were calling for its adoption by consensus. At the same time, he suggested that the term "*eau de boisson*" in the title of the French version of the draft resolution be replaced by "*eau potable*."

Dr ST JOHN (Barbados) recognized that the availability of potable water was the key to sustainable development: without it, all other development efforts were doomed to fail. Barbados, one of the world's most densely populated countries, was classified by the United Nations as a water-scarce country because it had 616 persons per square kilometre and renewable water resources estimated at 390 cubic metres per capita per year. Moreover, steady increases in population and in the tourism industry, and intensification of agriculture, were jeopardizing the quantity and quality of the island's groundwater reserves. In collaboration with the Inter-American Development Bank, the Government of Barbados had embarked on a 50-million-dollar project to improve the water distribution system and modernize the wastewater treatment system. The Government was also in the process of overhauling the groundwater protection zoning policy, and the water quality monitoring programme had been significantly strengthened. Barbados supported the draft resolution.

Mr PARRONDO BABARRO (Spain) observed that taking an "all-or-nothing" stand on the right to water and sanitation would not contribute to international recognition of that right. He therefore welcomed the inclusion in the draft resolution of language from United Nations General Assembly resolution 64/292 and Human Rights Council resolution 15/9, both of which presented the right as a component of wider essential human rights. He supported the draft resolution as both a contribution to improvement of access to drinking-water and sanitation and an appropriate response to environmental determinants of health. It should be adopted by consensus.

Dr WATT (United Kingdom of Great Britain and Northern Ireland) said that her Government was fully committed to supporting the achievement of the Millennium Development Goals and placed a high priority on providing the poorest people in the world with clean water and sanitation. Since March 2008 its bilateral programmes had helped 1.8 million people in Africa and 25.5 million people in South Asia to gain access to basic sanitation, and safe water had been delivered to 2.7 million people in Africa and 3.1 million in South Asia.

Her Government recognized human rights that had a clear basis in international human rights law, thereby enabling each State to be aware of its obligations to its people, and each individual to know what his or her rights were. It recognized a right to water as an element of the right of everybody to an adequate standard of living, and acknowledged that inadequate sanitation undermined the protection of human rights. It did not, however, consider that a "right" to sanitation currently existed under international human rights law. Nor was there an internationally agreed definition of what such a right would comprise.

The United Kingdom's legal position did not lessen the importance it ascribed to adequate sanitation and to the drinking-water, sanitation and hygiene issues underlying the draft resolution. But the priority that all attached to improving sanitation should not lead to a misdirected effort to recognize a new legal right without due regard for the structure of international human rights law. Thus while she did not wish to block consensus on the resolution, she regretfully had to dissociate herself from subparagraph 2(3) therein.

Mr DJABBAROV (World Vision International), speaking at the invitation of the CHAIRMAN, endorsed the report and the draft resolution. Sanitation and safe drinking-water were vital elements in

the fight to reduce preventable deaths; a common feature of the 30 countries with the highest death rate for children under five years of age was poor access to sanitation.

Drinking-water, sanitation and health issues, the control and prevention of cholera, and the eradication of dracunculiasis should be tackled with a coordinated approach and linked with the social determinants of health action plan to be developed later that year. At national level, public health strategies should be strengthened, intersectoral work reinforced, and planning and budgeting processes aligned.

He welcomed the inclusion in the draft resolution of the human right to water and sanitation and endorsed the request therein that the Director-General formulate a new, integrated WHO strategy for water, sanitation and health.

Dr NEIRA (Protection of the Human Environment) said that delegates' recommendations, observations and proposed amendments would be taken into account. In particular, she noted the requests for a more precise use of English and French terminology.

In response to the concern expressed by the delegate of Canada about the financial implications of the draft resolution, she said that the Secretariat planned to create synergies and merge programmes, in particular those related to risk assessment, risk management and water quality. At the same time, it recognized the need to extend its work on safety planning, particularly in the South-East Asia Region, and to look to the Asian Development Bank for investment. Monitoring also needed to be stepped up, particularly in view of the successful integration of indicators concerning the human right to water and sanitation. She was confident that major fundraising efforts would be successful as present-year results seemed promising; for example, donor pledges had been made at a recent meeting in Berlin to identify post-2015 water and sanitation indicators.

She confirmed that the Organization would be drawing up a new strategy on water, sanitation, hygiene and health, which would encompass all the elements mentioned in the draft resolution and be based on other successful strategies, such as the WHO/UNICEF Joint Monitoring Programme/Global Analysis and Assessment of Sanitation and Drinking-water.

She thanked the French delegation for strategic guidance and leadership during the consultations, not only on the draft resolution but also for the setting of priorities for the future.

Dr DAYRIT (Secretary) read out the proposed amendments to the draft resolution. Algeria, Cape Verde, Côte d'Ivoire, Kazakhstan, Maldives, Norway, Republic of Moldova and Uruguay should be added to the list of sponsors. The delegate of Bolivia had proposed that in the seventh preambular paragraph, all text following "and all human rights" should be deleted. In subparagraph 1(2), the delegate of Thailand had proposed that "empowerment, participation" should be inserted, following a comma, after "community education"; and in the same subparagraph, the delegate of Bolivia had proposed that "marginalized" be replaced by "the poorest". The delegate of Bolivia had proposed that in subparagraphs 1(3) and 2(3), "progressive" should be deleted. The delegate of Thailand had proposed that in subparagraph 1(5), "and implement" should be inserted after "prioritize".

Mr PELLET (France) welcomed the solid support for the draft resolution, underlining that consensus was within reach. He could accept some of the proposed amendments, but found it difficult to accept the deletion of the last part of the seventh preambular paragraph. The reference to Human Rights Council resolution 15/9 had been included in order to accommodate the views of the majority and was extremely important as it recalled language that had been previously agreed. He asked whether the delegate of Bolivia was prepared to be flexible on that point, given that his other proposed amendment, to subparagraph 1(2), was acceptable. The proposal to delete "progressive" from subparagraphs 1(3) and 2(3) was also difficult to accept, especially since the wording echoed paragraph 8(a) of Human Rights Council resolution 15/9..

The remaining amendments could be adopted, leaving only the title of the draft resolution in need of further discussion.

Ms BLACKWOOD (United States of America) said that she could endorse several of the amendments to the draft resolution but echoed the concerns of the delegate of France regarding the deletions proposed by the delegate of Bolivia.

Mr JAZAÏRY (Algeria) asked whether Member States would agree to replacing "*eau de boisson*" with "*eau potable*" in the title and body of the French version of the draft resolution. Other language versions would not be affected.

Mr ROSALES LOZADA (Plurinational State of Bolivia) reiterated that access to drinking-water was a fundamental right and was vital for life itself, as had been confirmed at the highest political level. He therefore did not see why a reference to it being a derived right should be included in the seventh preambular paragraph. Nevertheless, in the interests of consensus he would withdraw his proposed amendment to that paragraph.

He asked that other delegates show the same spirit of flexibility in accepting the deletion of "progressive" in subparagraphs 1(3) and 2(3), noting that there was no mention of "progressive" in paragraph 3 of Human Rights Council resolution 15/9. In his view, that term was redundant within the context of the realization of a human right, and if it were to be deleted in those two subparagraphs, as proposed, he would be willing to endorse the draft resolution.

Mr PELLET (France) read out paragraph 8(a) of Human Rights Council resolution 15/9, which called upon States "…to achieve progressively the full realization of human rights obligations related to access to safe drinking water and sanitation…".He could accept the proposal to delete "progressive" from subparagraph 2(3) but not from subparagraph 1(3), which addressed Member States.

Ms BLACKWOOD (United States of America) said that, although human rights were universal, aspects of their implementation and realization could vary from place to place. That was especially true of economic, social and cultural rights, which were to be realized progressively, consistent with States' available resources. It was therefore important, in her view, to retain the word "progressive", in particular in subparagraph 1(3).

Mr PELLET (France) averred that a consensus had been reached, on the understanding that "progressive" would be deleted from subparagraph 2(3) only.

Mr ROSALES LOZADA (Plurinational State of Bolivia) said that retaining "progressive" in subparagraph 1(3) but deleting it in subparagraph 2(3) was a fair solution, which he accepted.

Mr JAZAÏRY (Algeria) said that the delegate of France had signalled to him his approval of the proposal to replace "*eau de boisson*" with "*eau potable*". He therefore took it that his amendment would be included in the draft resolution, and would henceforth be integrated into general WHO terminology.

The draft resolution, as amended, was approved by acclamation.[1]

The meeting rose at 18:20.

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[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA64.24.