THIRTY-SEVENTH WORLD HEALTH ASSEMBLY

COMMITTEE A

PROVISIONAL SUMMARY RECORD OF THE SIXTH MEETING

Palais des Nations, Geneva
Monday, 14 May 1984, at 14h30

CHAIRMAN: Dr K. AL-AJLOUNI (Jordan)

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Note

This summary record is provisional only. The summaries of statements have not yet been approved by the speakers, and the text should not be quoted.

Corrections for inclusion in the final version should be handed in to the Conference Officer or sent to the Records Service (Room 4013, WHO headquarters), in writing, before the end of the Health Assembly. Alternatively, they may be forwarded to Chief, Office of Publications, World Health Organization, 1211 Geneva 27, Switzerland, before 2 July 1984.

The final text will appear subsequently in Thirty-seventh World Health Assembly: Summary records of committees (document WHA37/1984/REC/3).
SIXTH MEETING

Monday, 14 May 1984, at 14h30

Chairman: Dr AL-AJLOUNI (Jordan)

1. GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000: REPORT ON MONITORING OF PROGRESS IN IMPLEMENTING STRATEGIES FOR HEALTH FOR ALL: Item 19 of the Agenda (Resolutions WHA34.36, WHA35.23, WHA36.34 and EB73.R3; Documents EB73/1984/REC/1, Annex 1, A37/4, A37/5 and A37/INF.DOC./6) (continued)

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

The CHAIRMAN said that during the discussion at the previous meeting on the draft resolution proposed by the Executive Board in its resolution EB73.R6 there had been some confusion in regard to the amendments proposed. A number of interested delegations had in the meantime met as an informal working group and reached agreement on certain proposed amendments. The text would be circulated, and the draft resolution would be considered at a later stage.

Dr RAY (Secretary) read out an amendment submitted by the Egyptian delegation, consisting of the insertion of a new subparagraph of operative paragraph 4, worded as follows: "to take steps to review the global indicators and to further develop practical tools of measurement for these indicators to help Member States in their monitoring of progress towards the targets of the strategy".

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

Dr AL-AWADI (Kuwait) introduced the following draft resolution on behalf of the delegations of Bahrain, Iraq, Kuwait, Oman, and the United Arab Emirates:

The Thirty-Seventh World Health Assembly
Having considered the Director-General’s Report on the Spiritual Dimension in the Global Strategy for Health for All by the Year 2000\(^1\) and the recommendation of the Executive Board thereon contained in resolution EB73.R3;
Understanding the spiritual dimension to imply a phenomenon that is not material in nature but belongs to the realm of ideas, beliefs, values and ethics that have arisen in the minds and conscience of human beings, particularly ennobling ideas;

1. THANKS the Director-General for his report and the Executive Board for its recommendation;
2. CONCURS with the reflections contained in the report;
3. NOTES that ennobling ideas have given rise to health ideas which have led to a practical strategy for health for all that aims at attaining a goal that has both a material and non-material component;
4. RECOGNIZES that if the material component of the strategy can be provided to people, the non-material or spiritual one is something that has to arise within people and communities in keeping with their social and cultural patterns;
5. CONSIDERS that the realization of the health ideals that form the moral basis of the goal of health for all by the year 2000 will itself contribute to people’s feelings of well-being;
6. REALIZING that the spiritual dimension plays a great role in motivating people’s achievement in all aspects of life;

\(^1\) Document EB73/1984/REC/1, Annex 1.
7. ASSERTS in consequence that ennobling ideas have not only stimulated worldwide action for health but have also given to health, as defined in WHO's Constitution, an added spiritual dimension;

8. INVITES Member States to consider including in their strategies for health for all a spiritual dimension as defined in this resolution in accordance with their social and cultural patterns.

9. REQUESTS the Director-General to study further the role of the spiritual dimension in promoting the attainment of the goal of health for all by the year 2000.

Dr Al-AWADI (Kuwait) recalled that, after some discussion at the Thirty-sixth World Health Assembly, the subject had been referred to the Executive Board and the Director-General had prepared a report (Annex 1 to document EB73/1984/REC/1). Some delegations appeared to believe that the term spiritual dimension referred to the theological aspect, but the matter had been fully and clearly explained by the Director-General. Societies could only conduct their affairs properly in accordance with their traditional values, customs and beliefs. The spiritual dimension was what distinguished the actions of man from the instinctive reactions of animals. What was required was that every individual should not only be able to identify that dimension, but should also believe in it, so that the health-for-all strategy became an integral part of the daily life of every family, at work and at play, at home and in the street.

Every goal contained a material and a non-material element and the latter could only be achieved by a fully oriented effort of faith against the background of a society's traditional values. The draft resolution reaffirmed the ideas set out in the Director-General's report, enumerating clearly all the separate elements which went to make up the spiritual dimension, reminiscent of the definition of health in the Constitution of the World Health Organization. The heart of the resolution was contained in operative paragraph 8 which invited Member States to include a spiritual dimension in their health-for-all strategies so as to prevent any contradiction between social values and the principles of health care. He urged all delegations to support the draft resolution, in particular the developing countries since they were the ones who still possessed a great store of non-material values which should not be wasted or dissipated.

Dr SAVEL'EV (Union of Soviet Socialist Republics) said that the Thirty-sixth World Health Assembly, after considering the question of the spiritual dimension, had referred the subject to the Executive Board. The Board at its seventy-third session, had given careful consideration to the report prepared by the Director-General, and had adopted resolution EB73/R3, recommending that the present Health Assembly note the Board's conclusions. While agreeing that moral, ethical and social aspects and cultural traditions were very relevant to the implementation of the global strategy, he could not accept the concept of the spiritual dimension as outlined, for the reasons which he had explained in detail at the Thirty-sixth World Health Assembly. Since the Executive Board had already completed consideration of the matter, the Health Assembly could scarcely ask the Director-General to undertake a further study. He suggested that delegates might consider adopting only the first preambular paragraph and operative paragraph 1 of the draft resolution.

Dr BISHT (India) said that the idea of adding a further dimension to the definition of health had first been mooted at the Executive Board in 1978, since it was felt that the physical, mental and social dimensions were insufficient alone. He had pointed out at that time that, although a pack of wolves could be physically strong, mentally alert and socially well-knit, they still lacked something, and that lack distinguished them from human beings. A concept of health had to transcend mere animal health, and he had suggested that the difference could be defined by postulating a factor X which was an essential element in the health of the individual, the community and the State, and perhaps in the health of mankind as a whole.

At the request of the South-East Asia regional ACMR India had prepared a background document on the subject, and one conclusion had been the continuing need for research into the spiritual dimension. Not to be satisfied with the existing state of affairs provided the necessary stimulus to develop a society in which all individuals had the opportunity to enjoy what was commonly known as the quality of life. At the same time, as Socrates had said, the first step toward knowledge was to know that one knew nothing. It might be that we knew nothing of the spiritual dimension, but it could not be said that the spiritual dimension did
not exist, and it was a worthy aim to seek to find it. The key to health in all communities and throughout the world might well be the addition of the factor X - better expressed, perhaps, as "heart for all", defining the heart not in the anatomical but in the literary sense, as the centre of being.

Dr IVANOV (Bulgaria) said that the question of the spiritual dimension in the Global Strategy had been discussed at the Thirty-sixth World Health Assembly and, in consequence of the decision then taken, again at the seventy-third session of the Executive Board. His delegation fully endorsed the decision taken by the Executive Board on that question and therefore supported the amendment proposed by the delegate of the USSR.

Dr KLIVAROVA (Czechoslovakia) said that her delegation, which had participated in the discussions on the spiritual dimension at the Thirty-sixth World Health Assembly supported the views expressed in the Director-General's report and the recommendation of the Executive Board. The question had already been adequately covered and there was therefore no need for the Director-General or the Secretariat to consider the matter any further. Thus, at all events, operative paragraph 9 of the draft resolution should be deleted.

Professor SZCZERBAN (Poland) agreed with the previous speaker that operative paragraph 9 should be deleted. In view of the consideration that the matter had already received and of the recommendation of the Executive Board, no further study was required.

Dr AL-AWADI (Kuwait) feared that delegates might not have made a sufficiently careful study of the Executive Board's deliberations at its seventy-third session, or of the Director-General's report, and he quoted the conclusion from that report (paragraph 16). The Director-General's views had been endorsed by the Executive Board.

There was possibly some misunderstanding of the term "spiritual dimension". It was important to distinguish the spiritual dimension from the religious dimension. As the delegate of India had said, whatever one's ideology the spiritual dimension affected every human being as an integral part of his or her entire life. It was the only dimension that distinguished man from animals. The spiritual dimension should be safeguarded if values were to be preserved and health for all was to be attained. The draft resolution under consideration was in accord with the Director-General's conclusions and he urged delegates to give it their full support. Most countries recognized the value of the spiritual dimension. In his opinion, however, the question had not yet been properly studied and there was still confusion with the religious dimension, which was in fact a component of the spiritual dimension. The Director-General should be requested, therefore, to help Member States to incorporate the spiritual dimension in their strategies for health for all.

Dr LARIVIERE (Canada) commended the previous speaker on the way in which he had conveyed the message of the Director-General's report. His delegation supported many of the ideas incorporated in the draft resolution. WHO was moving towards the inclusion of the spiritual dimension in considerations of health. The delegate of India had indicated that the concept was not new to WHO; indeed it was not limited to WHO. The agenda of the recent meeting of UNICEF's Executive Board had included an item on the psychosocial aspects of child development. Psychosocial considerations presupposed that human beings were spiritual and loving creatures. The spiritual dimension was an intrinsic part of the word "care" for health care workers and health care services. However, the spiritual dimension in the Global Strategy should not become a new research programme for WHO; rather, it should be a concept that would be borne in mind in developing and implementing health programmes.

The proposal of the delegate of the USSR to delete all but the first preambular paragraph and operative paragraph 1 of the draft resolution was rejected by 19 votes to 10, with 60 abstentions.

The proposal of the delegate of Czechoslovakia to delete operative paragraph 9 of the draft resolution was approved by 28 votes to 19, with 31 abstentions.

The draft resolution, as thus amended, was approved by 55 votes to none, with 31 abstentions.
Basic plan on priority health needs of Central America and Panama

Dr GARCIA GARCIA (Panama) introduced the following draft resolution, on behalf of the delegations of Antigua and Barbuda, Argentina, Bahamas, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Spain, Trinidad and Tobago, Uruguay, and Venezuela:

The Thirty-seventh World Health Assembly,
Informed of the initiative taken by the governments of the countries of Central America and Panama, embodied in the "basic plan on priority health needs" in that subregion, which they have drawn up in concert and are mutually committed to executing;
Considering the special significance of this initiative for social development, for the solution of health problems, and as a link to promote understanding, solidarity and peace among the peoples of Central America and Panama at a particularly difficult juncture in their history;
Noting that this initiative is in keeping with the principles of solidarity and cooperation that guide WHO's activities aimed at the attainment of the goal of "Health for All",
1. CONGRATULATES the governments of the countries of Central America and Panama on this initiative;
2. EXPRESSES its full support for the initiative and the measures for implementing it properly;
3. INVITES WHO Member States to support the initiative effectively and to the fullest extent possible;
4. RECOMMENDS that the Director-General take appropriate action and seek any possible means of supporting the implementation of activities aimed at ensuring the success of the initiative; and
5. REQUESTS the Director-General to submit a report on the matter to the Thirty-ninth World Health Assembly.

He recalled that at the fifth plenary meeting the Minister of Health of Panama had informed the Health Assembly that the countries of the Central American Isthmus hoped to achieve peace through a plan for health as a source of and bridge to peace; it was hoped that implementation of the plan would enhance the efforts of the Contadora Group to secure the well-being of the people of the region. He expressed the hope that all delegations would vote in favour of the draft resolution.

Dr LARIVIERE (Canada) and Miss BELMONT (United States of America) said that their delegations wished to cosponsor the draft resolution.

Dr JAW CHONG (Suriname) said that his delegation fully supported the draft resolution.

The draft resolution was approved.

Health for All by the Year 2000

The CHAIRMAN invited the Committee to consider the following draft resolution, submitted by the delegations of Afghanistan, Democratic People's Republic of Korea, India, Mozambique, and Yugoslavia:

The Thirty-seventh World Health Assembly,
Noting with satisfaction the decisions taken by a group of Member States - the Non-aligned and other Developing Countries - concerning the implementation of the Strategy for Health for All by the Year 2000;¹

¹ Document A37/INF.DOC./6.
Recognizing the importance of the decisions adopted by the Non-aligned and other Developing Countries in their resolutions on:

(i) implementation of the Strategy for Health for All by the Year 2000;
(ii) Technical Cooperation among Developing Countries to attain the goal of Health for All by the Year 2000;

1. CONGRATULATES the Non-aligned and other Developing Countries on their continuing political commitment and vigorous efforts to attain the goal of Health for All;

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

The draft resolution was approved.

Technical Cooperation among Developing Countries in Support of the Goal of Health for All

Miss Illic (Yugoslavia) introduced the following draft resolution, on behalf of the delegations of Afghanistan, Algeria, Angola, Argentina, Bangladesh, Cape Verde, China, Cuba, Cyprus, Democratic People's Republic of Korea, Egypt, Guyana, India, Indonesia, Jordan, Libyan Arab Jamahiriya, Malta, Mozambique, Pakistan, Sao Tome and Principe, Sri Lanka, Suriname, Thailand, Tunisia, United Republic of Tanzania, Yugoslavia, and Zambia:

The Thirty-seventh World Health Assembly,
Reaffirming its conviction that technical cooperation among developing countries (TCDC) constitutes an important vehicle for health development and for the implementation of national health strategies;
Bearing in mind the resolutions of the United Nations General Assembly encouraging technical cooperation among developing countries, and its endorsement of the Declaration and the Plan of Action of the Buenos Aires Conference on TCDC in 1978;
Recalling resolution WHA30.43 which called on all countries to collaborate in the achievement of the goal of health for all by the year 2000, and resolution WHA32.30 endorsing the Declaration of the International Conference on Primary Health Care;
Taking into account resolution WHA31.41 which urged the strengthening of technical cooperation among developing countries and the active collaboration between WHO and the developing countries in the promotion of such programmes;
Taking note of resolution WHA35.24, adopted by the World Health Assembly, congratulating the non-aligned and other developing countries on their expression of political commitment to the goal of health for all;
Noting with satisfaction the adoption by the Ministers of Health of non-aligned and other developing countries of a Medium-term Programme on TCDC for Health for All (1984-1989) and an Initial Plan of Action on TCDC for Health for All (1984-1985), as a contribution by developing countries towards the implementation of the Seventh General Programme of Work;

1. WELCOMES the launching by non-aligned and other developing countries of the Medium-term Programme (1984-1989), together with the Initial Plan of Action (1984-1985), being convinced that these initiatives will contribute to reinforcing the implementation of national health strategies;

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

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

4. EMPHASIZES in this connection the importance of reinforcing multilateral institutionalized cooperation within the framework of priorities fixed by the developing countries and including cooperation among these countries;
5. REQUESTS the Director-General to support these programmes drawing upon the technical and financial means at his disposal, and to mobilize technical and financial support for the Medium-term Programme, the Initial Plan of Action and other TCDC programmes and activities, by strengthening collaboration with other components of the United Nations system and with other international organizations.

The sponsors wished to make a technical correction to the end of the third preambular paragraph, which should read: "the Alma-Ata Declaration of the International WHO/UNICEF Conference on Primary Health Care". The sponsors were unaware of any objections to the text, and hoped that it would be approved without a vote.

Dr OLIVER (United Kingdom of Great Britain and Northern Ireland) said that operative paragraph 3 as drafted gave the impression that the developed countries were not yet helping the developing countries. He proposed that the words "continue to" be inserted between the words "to" and "provide".

His delegation did not understand the meaning of the words "multilateral institutionalized cooperation" in operative paragraph 4.

Miss ILIC (Yugoslavia) said that the sponsors could accept the amendment to operative paragraph 3 proposed by the delegate of the United Kingdom.

"Multilateral institutionalized cooperation" meant cooperation through established channels such as WHO and other organizations of the United Nations system.

The draft resolution, as amended, was approved.

Monitoring progress in implementing strategies for health for all by the year 2000 (continued)

The CHAIRMAN drew the Committee's attention to the text of the draft resolution incorporating the amendments proposed at the previous meeting, reading as follows:

The Thirty-seventh World Health Assembly,
Reaffirming resolutions WHA30.43, WHA34.36 and WHA35.23 concerning the policy, strategy and plan of action for attaining the goal of health for all by the year 2000;
Recalling resolution WHA33.17 concerning the concentration of the Organization's activities on support for the attainment of this goal;
Noting that the attainment of the goal of health for all by the year 2000 is intimately related to socioeconomic development, and commitment to and the preservation of world peace;
Recognizing the determination of all countries to contribute fully to achieving the goal of health for all through reinforcement of individual and collective self-reliance, of which technical cooperation among developing countries is an essential element;
Aware that cooperation among all countries and support by developed countries and international organizations, including the principles of a new international economic order, can significantly contribute to a more rational use of available resources;
Recognizing that monitoring and evaluation are fundamental elements of the managerial process required for the implementation of the strategies, and that the commitment and courage of Member States and a spirit of mutual trust among them are essential for the effective implementation of the Strategy for Health for All;
Mindful that only three-quarters of the Member States have submitted progress reports in due time on the implementation of their national strategies;
Noting the progress made thus far in the implementation of the Strategy, but also being aware of the magnitude of the overall task and the relatively short period left to achieve the collectively agreed goal of health for all by the year 2000;

1. URGES Member States:
   (1) to accelerate the reorientation and the modifications of health systems towards primary health care, further strengthen the managerial capacity of their health system, including the generation, analysis and utilization of the information needed, and emphasize continuing education of health personnel to support their health management process;
   (2) to accord the highest priority to and assume full responsibility for the continuing monitoring and evaluation of their strategies, individually as part of their managerial process for national health development, and collectively in a spirit of mutual trust in order to identify jointly factors which contribute to or impede the implementation of the Strategy;
(3) to further refine and update as necessary their national strategies and plans of action for health for all, with clearly defined objectives and targets and appropriate allocation of resources, and apply corrective measures required for accelerating the pace of implementation of their national strategies;
(4) to promote the importance of multisectoral approaches and their linkages to achieve health for all;
(5) to pay attention to the planning and evaluation of health manpower development programmes consonant with the needs of their health systems;
(6) to accelerate efforts to mobilize national and external resources in support of activities that are essential to the implementation of the strategies, ensuring that these resources are adequately directed towards underserved and socially and geographically disadvantaged groups;
(7) to use WHO's resources optimally, directing them to the mainstream of activities required to implement, monitor and evaluate the national strategy;
(8) to consider the desirability of enacting health legislation incorporating the basic principles of health for all;

2. URGES the regional committees:
(1) to give increased attention to the review and analysis of the findings of the monitoring and evaluation of national strategies by Member States in the region;
(2) to identify factors and issues facilitating or impeding the implementation of national strategies in the region and promote the required action to foster positive factors and to resolve impeding issues;
(3) to stress the importance of mutual cooperation among Member States in this process;
(4) to carry out a first evaluation of the regional strategy in 1985 in keeping with the plan of action for implementing the Global Strategy for Health for All;

3. REQUESTS the Executive Board:
(1) to continue to monitor actively the progress in implementing the Global Strategy, identifying issues and areas requiring action by Member States individually and collectively;
(2) to participate actively in the Organization's efforts to support the Member States in the implementation of national strategies as well as the monitoring and evaluation activities;
(3) to carry out a first formal evaluation of the Global Strategy and submit its report thereon to the Thirty-ninth World Health Assembly in 1986, in keeping with the plan of action;

4. REQUESTS the Director-General:
(1) to focus further the resources of the Organization to accelerate and improve the implementation of the Strategy for Health for All;
(2) to ensure the provision of intensive, appropriate and targeted support to Member States for the implementation, monitoring and evaluation of the Strategy, especially in countries where the needs are greatest and which are ready for it;
(3) to call upon the developed countries to provide urgent and appropriate technical and economic support to developing countries on a bilateral basis or through WHO, other United Nations agencies and international organizations;
(4) to intensify technical cooperation with Member States in order to strengthen their managerial capacities, including monitoring and evaluation and the related generation, analysis and use of supporting information;
(5) to take steps to review the global indicators and to further develop practical tools of measurement for these indicators to help Member States in their monitoring of progress towards the targets of the Strategy;
(6) to further strengthen collaboration within the United Nations system and with other intergovernmental, nongovernmental and voluntary organizations in their respective fields of competence to provide countries with technical and financial support in attaining the goal of the health for all.

The draft resolution, as amended, was approved.
2. INFANT AND YOUNG CHILD NUTRITION (PROGRESS AND EVALUATION REPORT; AND STATUS OF IMPLEMENTATION OF THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES):

Item 20 of the Agenda (Resolutions WHA33.32 and WHA34.22; Documents WHA34/1981/REC/1, Annex 3, Article 11.7 of the Code, and A37/6) (continued)

Dr ELIAS (Hungary) said that the importance of adequate nutrition for infants and young children in the struggle for health for all could not be overemphasized. Although starvation and famine were virtually unknown in Hungary, malnutrition was a major public health problem. Growth deficiencies attributable to various causes also posed an increasing number of problems.

Since deficiency anemias occurred in infants and young children, pregnant women were screened thoroughly, as were the infants and young children themselves. When required, changes in diet were introduced and pharmaceutical preparations were administered under medical supervision.

His Government had been combating iodine deficiency for decades, with a measure of success. Schoolchildren were regularly checked for goitre and the results obtained were used to identify areas where iodized salt should be more extensively used. In 1983 a programme had been introduced for screening infants and young children for congenital thyroid deficiency.

Several national institutes had set up teams to work in the field of early detection and treatment of diseases and growth deficiencies caused by malabsorption. Special foodstuffs and financial assistance were made available to affected families.

Vitamin A deficiency was uncommon in Hungary and when it did occur it was usually attributable to disease, rather than malnutrition.

There was a large-scale programme aimed at integrating children with systemic diseases into normal child communities and thus enabling them to live like healthy children. Group activities and holidays were organized for them and where possible they attended normal schools. In that way, such children were helped to overcome their social handicap.

Breast-feeding was encouraged by the appropriate professional and non-professional organizations and community groups. The results were not spectacular; the proportion of infants over four months old fed on maternal milk had increased from 31% in 1977 to 39% in 1983. No effort was spared in school education to make the importance of breast-feeding understood at an early age. Materials emphasizing the significance of breast-feeding, and describing the methods of promoting it had increasingly been included in professional and medical training. The provisions of resolutions WHA33.32 and WHA34.22 on the marketing of breast-milk substitutes were implemented in his country. Maternal milk substitute preparations, including those made in Hungary, were available on medical prescription and were obtainable free of charge. In the case of products for older infants, the label had to show that the product was no substitute for maternal milk. The quality of the maternal milk substitutes made in Hungary was up to international standards advocated by WHO.

Hungary fully supported the efforts of WHO to improve infant and child feeding and his Government gave all possible assistance to countries requesting it.

Dr NJIE (The Gambia) said that breast-feeding was still practised almost universally in the Gambia. That, however, was not a cause for complacency; for an undesirable trend away from it had been observed among working mothers in urban areas.

The promotion of breast-feeding was desirable but should be conducted carefully in order to avoid misleading mothers. There was scientific evidence to show that breast-feeding alone was not adequate for child growth after the third or fourth month, as most mothers in his country were well aware. The problem lay not in the introduction of weaning foods but in their quality and type. Experience in the Gambia showed that the weaning foods used left much to be desired in nutritional content as well as, in many cases, being vehicles of infection, thus causing recurrent gastroenteritis. A child growth surveillance system had been in operation for many years, but a recent evaluation had shown up major weaknesses. There was 90% enrolment of newborns in the maternal and child health services, but although children were weighed regularly, the service was being used mechanistically and signs of malnutrition were going undetected for months. A project was being developed with United Kingdom cooperation for the control of the communicable diseases of childhood, under which staff would be trained to ensure that basic surveillance was translated into timely intervention.

Unfortunately, food and feeding, although important, did not in themselves provide an adequate answer to the problems of infant and child nutrition, which were multifaceted and bound up with other health as well as social and cultural factors.
They were inextricably bound up, for instance, with problems of infection. It was recognized that the child in the developing world spent one-third of its first year of life in a state of illness. It had been found also that in almost every case of severe malnutrition there was concurrent infection, particularly lower respiratory tract infection, gastroenteritis and skin infections. Prevention of infection, through such programmes as the expanded programme on immunization, malaria control and the control of diarrhoeal diseases, would do much to improve infant and young child nutrition.

The role of women in developing countries was another important aspect of the problem. They were overworked and overburdened with a rapid succession of pregnancies. The arduous manual responsibilities of mothers on the land, in addition to domestic work, drained them of vitality. So much so that, in his country, a programme of supplementary feeding for mothers in the third trimester of pregnancy had failed to show the expected benefits in the mothers themselves, though it had improved the birth weight of their infants and lactational performance. In the absence of effective measures to ease the role of women, child development would continue to suffer.

Man-made and natural disasters were continuing to hamper economic development in many parts of the world and cooperation between the developed and the developing countries had been a leitmotiv of the discussions so far. That cooperation was no less important in the field of child nutrition. For instance, the continuing desertification of the Sahel was bringing famine and starvation to areas where they were previously unknown and those who suffered most were, as always, the children and their mothers. Supplementary feeding programmes particularly when, as was often the case, they took no account of national self-reliance, were no substitute for sustained intersectoral cooperation.

The fields he had mentioned were just a few of those that illustrated the multifaceted nature of the problem. Progress towards a solution called for cooperation and coordination between health programmes, between the health and other sectors and between developed and developing countries. Indeed he was not far from thinking that, since proper child growth and development could be achieved only through that kind of full deployment of the strategies, it could serve as a measure of their effectiveness, presupposing as it did progress with the other indicators. It was indeed the focus of the challenge since it was crucial to the attainment of health for all by the year 2000.

Dr EL BERMAWI (Egypt) said that his delegation wished to co-sponsor the draft resolution on the prevention and control of vitamin A deficiency and xerophthalmia.

He expressed his satisfaction with the Director-General's report. It indicated a global decrease from 17% to 16% in the estimated proportion of low-birth-weight infants; however, it should not be overlooked that the absolute numbers had remained nearly the same and exceeded 20 million. Moreover, that global figure should not hide the fact that in certain countries with a total combined population of about 10 thousand million, the proportion of low-birth-weight infants remained unchanged and was very high, ranging between 30% and 50% of live births.

The report also provided an overall view of activities and measures taken to encourage breast-feeding, to improve weaning practices, to strengthen nutrition education and information, and to develop support for the improved health and status of women. In those fields, Egypt's civil service regulations provided for fully-paid maternity leave for three months after delivery; a nursing mother was allowed one hour per day of working time for breast-feeding throughout one year; and, on request, mothers were granted two years' unpaid maternity leave for breast-feeding and child care.

Where nutritional deficiencies were concerned, the iodization of salt and the introduction of canned sea-fish into the diet of the people in the few areas where goitre had been endemic, accompanied by an intensive nutrition education programme, had sufficed to eliminate the problem.

He fully agreed with the report's conclusion but would like to add to the interacting factors, enumerated in paragraph 222, that were important to nutritional status of children, family size, family income, parents' education, food distribution within the family, and local food traditions and eating habits. With regard to paragraph 226, he wished to emphasize that national strategies should combine the efforts of both governmental and nongovernmental sectors. The governmental sphere should include the various sectors of health, agriculture, education, the food industry and food importation, while community participation should be through voluntary associations, women's organizations and consumer groups. Both should have the support of strong intersectoral collaboration.

He recalled that in the Introduction to the Proposed programme budget for 1984-1985 it was stated that social needs should dictate priorities. Everyone agreed that malnutrition was, and would remain, an important factor contributing to high infant and child mortality;
those who survived suffered from retarded growth, low resistance to infections, and environmental hazards. The Director-General's report indicated that nutritional anaemia affected two-thirds of pregnant women and half the non-pregnant women in developing countries; if so, about 290 million women were suffering from nutritional anaemia in those countries, the population of which was steadily increasing and, with it, the numbers in the vulnerable groups. Yet the total provision for nutrition programmes was 6.5% less in 1984-1985 than in the previous biennium, and 37% less for the Eastern Mediterranean Region. If allowance were made for continuing inflation at the rate of 17.4%, the real decrease in total budget would reach about 24%. His delegation raised that issue so that it would be taken into account in the preparation of the proposed budget for 1986-1987.

Professor ORDOÑEZ CARCELLER (Cuba) said that for the past 25 years his Government had implemented national programmes which included improvement of maternal and child nutrition through the promotion of breast-feeding, the supervision of adequate weaning procedures, and the development of health education with special reference to the status of women and rational and appropriate marketing of breast-milk substitutes. Those programmes had been closely integrated with primary health care which, in Cuba, was available to the entire population.

In the second half of the preceding decade, Cuba had instituted a national nutritional surveillance programme for infants and young children. In 1972, a national study on growth and development had been carried out, using a random sample of more than 50,000 children from birth up to 20 years of age, which included the recording of 15 anthropometric measurements, sexual development and bone maturation. As a result, national growth and development standards had been adopted for application countrywide. The study had been repeated in 1982 and the data were now being processed and analysed. The study, together with perinatal research follow-up to the age of seven years, and a more recent study of risk factors during gestation, together with the nutritional surveillance programme and the continuing statistics of the national health system, enabled the Cuban Government to analyse the nutritional status of the country in depth.

The national study on growth and development had shown that during the first six years of life the weight-for-height standards in Cuba were in line with the most recent figures of the United States National Center for Health Statistics which had been taken as reference standards by WHO. Infant mortality in Cuba for 1983 was 16.8 per 1000 live births and the corresponding rate for 1 to 4 year-old children was 9.8 per 1000 population. The results of the national surveillance programme had demonstrated that in the past two years the proportion of children under one year suffering from undernutrition was 4%, using the Harvard standard. Although malnutrition among children due to physical defects was a thing of the past, malnutrition from overfeeding and obesity affected 9.8% in the same age-group nationwide and was increasing with its repercussions on health in the short- and long-term.

With regard to the improvement of the status and health of women, the protection of pregnant women at work was guaranteed by law in Cuba, an important provision since 38.9% of the active labour force consisted of women, who also constituted 53% of the working population with technical qualifications. In addition to the special diet which pregnant women were allowed, evaluations made by international organizations indicated that there was a daily average per capita calorie intake of 2855 calories, with a daily consumption of almost 80 g of protein.

Where the marketing and distribution of breast-milk substitutes were concerned, their production in Cuba was in the hands of a non-profit-making State enterprise that came under the Ministry of Food. Consequently, there was no direct advertising to doctors or any members of the health team, nor any advertising in the mass media; no free samples were distributed to mothers in order to promote sales. In short, there was no problem in Cuba, regarding the implementation of the International Code adopted by WHO because the system worked against any attempt to profit at the expense of the health of the people.

In conclusion, he referred to future projects in Cuba. The system of nutritional surveillance would be structurally improved. The changing socioeconomic situation required a constant search for indicators that would better reflect the problems inherent in each phase of development. Consideration was being given to the inclusion of new indicators such as the weight and height of schoolchildren at seven and 12 years of age, as well as of adults attending the primary health centres. Special attention would be given to the problems of obesity and the need for more specific measurement of body fat bearing in mind the need for indicators to be simple and usable.

Another very important problem was to adapt the results of national growth and development study for use as reference standards for anthropometric purposes, improving the primary data through training and supervision of personnel and accelerating data analysis by
computerization in order to speed up the consolidation of the information and feedback to local units. It was planned to develop the surveillance system, at present limited to the health sector, through an integrated approach to include indicators of the level of health, and concerning the production, processing and distribution of foods. The prerequisites for these developments already existed since the national nutrition programme was based, at the municipal, provincial and national levels, on the existing structures of the people's government at those levels; and it coordinated and advised all the sectors participating in the food-nutrition chain, influencing State and community decisions from supply to consumption.

Dr WILLIAMS (Nigeria) commended the Director-General on his comprehensive report. The data provided on the incidence of low birth weight in the developing countries gave great cause for concern. In Nigeria low fetal weight and low birth weight were still major causes of stillbirths and infant deaths in the first month of life. Many of the developing countries did not possess the skilled manpower or the facilities to provide the necessary care for low-birth-weight children. The provision of proper prenatal care and supervision, still regrettably lacking for most mothers in Third World countries, would significantly reduce the incidence of low birth weight and maternal morbidity and mortality and increase the chances of infant survival. It should be focused on low-income and socially disadvantaged women, and should be well organized and readily available.

He welcomed the prominence given in the report to the connection between closely-spaced pregnancies and low birth weight, and stressed the importance of family planning in that respect, while conceding that family planning, often equated with population control, was a highly delicate issue in many African countries. He believed that it should be promoted more forcefully by the Organization as a means of improving maternal and child health and fostering infant and child survival.

The Organization's leadership role with regard to infant and young child nutrition was widely recognized. His Government had placed the import of breast-milk substitutes under special licence, thereby reducing the quantities imported and placing the limited quantities available on the domestic market beyond the economic reach of the average consumer. The proportion of breast-feeding mothers appeared to be rising again. He felt sure that encouragement of breast-feeding, coupled with the programme of the International Drinking Water Supply and Sanitation Decade would result in a significant reduction of diarrhoeal diseases, still the main cause of child mortality and morbidity in his country.

In connection with the introduction of protein-rich weaning food, his country's institute of industrial research had developed an excellent product but was having difficulty in finding industrial sponsors to produce and market it commercially.

A programme was shortly to be launched in Nigeria to control vitamin A deficiency in response to reports of its high incidence among children in the northern part of the country.

The Nigerian Government, aware of the prevalence of malnutrition, aggravated by drought, was placing renewed emphasis on investment in agriculture to ensure food self-sufficiency and the availability of food at affordable prices. Short-term deficiencies in food production were being met by imports, while active steps were being taken to ensure that the food was being channelled to those most in need, through improved distribution and storage.

Dr KAKITAH (Uganda) said that nutritional deficiencies were still a major cause of child morbidity and mortality in his country, especially in the under-five age-group. Malnourished mothers often gave birth to underweight babies whose normal growth and development were further hindered when they grew up in underprivileged areas. The chances of adequate infant and young children nutrition would therefore be enhanced if concurrent measures were taken to improve both maternal nutrition and infant and young child feeding.

Breast-feeding was a matter of course in Uganda, and the small quantities of imported breast-milk substitutes did not reach the rural areas. That trend would be maintained by ensuring a responsible attitude towards the use of substitutes if it proved necessary.

Through the primary health care network, more emphasis had been placed on health education to encourage mothers and the community as a whole to use locally available weaning foods and to encourage good and timely weaning practices. He appealed for more support from the Organization and other United Nations agencies such as FAO and UNICEF to help developing countries to produce weaning foods from local resources.

His Government had been represented at the conference, held in Swaziland, to which the delegate of Swaziland had referred, and his delegation conveyed to the Committee its approval of ideas expressed on that occasion, including the Mbabane Declaration. He endorsed the comments she had made in that connection.
His delegation wished to co-sponsor the draft resolution on infant and young child nutrition proposed by the delegations of Bahrain, Egypt, Kuwait, Qatar and the United Arab Emirates but wished to suggest a few amendments. In the first preambular paragraph, the symbols WHA27.23 and WHA32.47 should be amended to WHA27.43 and WHA31.47 respectively. The phrase "with particular emphasis on the use of foods of local origin" should be added at the end of operative paragraph 2, and operative paragraph 3 should be reworded to read:

REQUESTS the Director-General: (a) to continue and intensify collaboration with Member States in their efforts to implement and monitor the International Code of Marketing of Breast-milk Substitutes as a minimum measure at the national level; (b) to take steps to monitor the inappropriate promotion and use of foods unsuitable for infant and young child feeding; and (c) to report to the Thirty-ninth World Health Assembly on progress in implementing this resolution together with recommendations for any other measures needed to further improve sound infant and young child feeding practices.

Dr ABBAS (Somalia), expressing his appreciation of the Director-General's report (document A37/6), pointed out that poverty was one of the main determining factors in malnutrition, and consequently that a study of the incidence and causes of poverty was of great importance when planning measures to improve health and nutrition.

Massive rural-urban migration, with its attendant ills, was a grave problem in Somalia, as in most developing countries. His Government had given it serious consideration when drawing up the current five-year development plan, a guiding principle of which was to improve the quality of life in rural areas, where the proportion of households living under the poverty line was estimated at 76%, as against 49% among nomads and 42% in urban areas. Malnutrition and undernutrition were the direct result of a number of interrelated factors associated with poverty. Among the most deprived sectors of the population the inability to obtain the bare minimum of even staple foods was accompanied by illiteracy, unsatisfactory environmental conditions, and natural and man-made disasters such as drought and war - all of which aggravated the situation.

Several important studies and surveys had been carried out in his country, confirming that protein-energy malnutrition was a major problem among infant and pre-school children in Somalia. The decline in growth after the age of eight months was attributed to the combined effect of inadequate supplementary feeding and repeated infections. It had been found that a high percentage of children received no food other than milk until their second year of life. The problem of low birth weight was exacerbated by the fact that many women deliberately lowered their food intake during the final three months of pregnancy in order to give birth to a smaller baby and have an easier delivery. The National Health Plan (1980-1985) estimated that 26% of children below five years of age could be classified as suffering from grade II and grade III malnutrition. The 7% incidence of grade III malnutrition reported in the National Health Plan was a matter of grave concern when seen against the 2 to 3% incidence reported in WHO's analysis of 101 surveys in 59 countries.

Health service reports indicated a high prevalence of anaemia in his country, with an incidence of 50% among pregnant women and women of child-bearing age.

A national conference on food and nutrition organized by his Government in collaboration with WHO and UNICEF had proposed a series of recommendations designed to improve the critical nutrition situation in his country. It was now hoped that the assistance to be provided by the Joint WHO/UNICEF Nutrition Support Programme would reinforce the Government's resources and efforts to develop the technical and managerial capacity to plan and implement a comprehensive set of measures to improve the health and nutritional situation of mothers and children.

While Somalia subscribed to the International Code of Marketing of Breast-milk Substitutes, the influx of refugees, currently numbering over half a million, posed a serious threat to effective implementation of the Code, since large quantities of breast-milk substitutes were entering the country. Such generous and well-meaning donations were indeed appreciated and were often the sole means of ensuring the survival of the communities concerned. His delegation would welcome any suggestions as to possible ways of dealing with that critical problem.

The meeting rose at 17h30.