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THIRTY-NINTH WORLD HEALTH ASSEMBLY

COMMITTEE A

PROVISIONAL SUMMARY RECORD OF THE TENTH MEETING

Palais des Nations, Geneva
Wednesday, 14 May 1986, at 14h30

CHAIRMAN: Dr J. M. BORGOÑO (Chile)

CONTENTS

		Page
1.	Tobacco or health (continued)	2
2.	Global Strategy for Health for All by the Year 2000 (continued)	5
	Economic dimension (continued)	5
3.	Infant and young child nutrition (continued)	9
4.	International Drinking Water Supply and Sanitation Decade	10

TENTH MEETING

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Chairman: Dr J. M. BORGOÑO (Chile)

1. TOBACCO OR HEALTH: Item 22 of the Agenda (Document EB77/1986/REC/1, Resolution EB77.R5 and Annex 3) (continued)

Dr GRABAUSKAS (Director, Division of Noncommunicable Diseases), replying for the Director-General and his staff, thanked the delegates for the immense support they had given to WHO's programme on tobacco or health and for their helpful comments and guidance for the further programme implementation that was so crucial for the improvement of people's health.

Regarding the scope and intensity of WHO's involvement and leadership in combating the tobacco epidemic worldwide and replying in particular to the intervention by the representative of the International Organization of Consumers Unions, he stressed that the administratively and programmatically identifiable smoking or health programme, with its staff and regular budget, was in addition considerably supported in its implementation by allocations from the Director-General's Development Programme and from extrabudgetary resources. Other technical programmes within the Division of Noncommunicable Diseases, such as those on cancer, cardiovascular diseases, other noncommunicable diseases with its respiratory disease component, oral health, occupational health and the integrated programme for community health in Non-communicable Diseases had very strong tobacco components in their action programmes at country level, which in the case of cancer were spending on tobacco issues up to a third of their operational budgets, not to speak of the staff time involved. IARC was most actively studying tobacco and cancer issues; in the recently published IARC Monographs Numbers 37 and 38 on tobacco and its effects, a comprehensive scientific review of existing data had led to a very clear conclusion: any tobacco use, including chewing and passive smoking, was detrimental to health.

The programmes he had mentioned were being undertaken in close collaboration with those of the Division of Public Information and Education for Health, which, together with the programmes for health legislation and the protection and promotion of mental health were most actively involved in health education and activities of the global advocacy type, and contributed jointly to an overall programme implementation tapping considerable resources. Active and aggressive tobacco control programmes already existed, or were being designed and implemented, in virtually every WHO Region. The involvement of some United Nations agencies and nongovernmental organizations was being utilized to stimulate and provoke an anti-tobacco action at global and national level.

All that was meant to indicate clearly that WHO had a very broad tobacco or health programme. There was definitely a need for better coordination of all those activities at various levels between general health promotion, advocacy and technical programmes, as had been mentioned by the delegates of the German Democratic Republic and the Union of Soviet Socialist Republics, and for taking account of economic aspects, as had been indicated by the delegates of Malawi, Kenya, Japan, Ghana, Cameroon and Zimbabwe. As the United Kingdom delegate had clearly stated, a balanced approach and a stepwise aggressive implementation should be regarded as a conditio sine qua non for the success of that important and critical programme.

WHO, in particular with its technical programmes, had definitely moved from rhetoric to action; however, a further move was required from preaching to the converted to reaching all those in need. WHO's technical programmes, through interdisciplinary and intersectoral cooperation, were ready to make their major contribution. Tobacco was being combated, not because it was a bad habit, but because it resulted in ill health. To be aggressive in action and, on the other hand, balanced and realistic, there was a clear need for a reciprocal reaction and commitment from the countries themselves, including extrabudgetary support to WHO.

Dr MASIRONI (Smoking and Health) joined Dr Grabauskas in thanking the delegates for their encouraging and constructive comments on the programme itself and on the Director-General's report which had been prepared in close consultation not only with the other members of the staff, but also with regional offices, IARC, specialized agencies of the United Nations, nongovernmental organizations and individual experts. It was gratifying that many delegates felt the report to be valuable enough to justify wide distribution in an appropriate format. The large number of speakers had indicated widespread concern for an issue that was no longer limited to smoking and health but was to be expanded to cover the

whole issue of tobacco or health. Another indication of concern, as pointed out by the delegate of Nigeria, was that smoking and health had been almost a constant issue at every session of the Executive Board and Health Assembly in recent years. Such continuing attention was welcome, since it provided the Organization with guidance and encouragement in carrying out the programme.

A great many examples had been mentioned of country action to stem the spreading of smoking and related diseases. Some delegates had expressed concern over the economic importance of tobacco for their countries and had asked what WHO could propose in the way of economically viable alternatives. WHO had not under-estimated the dilemma, on one hand tobacco was a major cause of disease worldwide; on the other, it was a source of revenue and labour. In the fields of economics and agriculture, WHO had limitations, but in spite of them it had began to tackle the problem. For instance, a pilot study on the health and economic implications of tobacco consumption in developing countries had been started in collaboration with the National Cancer Institute of the National Institutes of Health in the United States, involving Egypt, Thailand and a major tobacco-producing country, Brazil. A WHO reference centre dealing with economic issues of smoking and health had been operational for several years in Canada and could provide advice. FAO and the World Bank had been approached and indeed FAO had produced, at the prompting of WHO, a report entitled The economic significance of tobacco, large sections of which had been quoted in the Director-General's Report. FAO was also considering the preparation of a document on tobacco projections to 1990.

FAO and the World Bank had repeatedly made known at WHO meetings in Geneva and Washington that they were, upon request, at the disposal of Member States to study possibilities for tobacco crop diversification. WHO could assist, but it was up to the Member States themselves to take up the issue with FAO and the World Bank, and perhaps other agencies.

Secondly, in order to allay the fears of some delegations it could be pointed out that no matter how hard the health and education sectors worked, both at global and country levels to control the spread of tobacco use, tobacco would not be phased out over night. It would take many years for tobacco use to decrease so far as to make tobacco production economically unattractive. That length of time would give the opportunity for everyone involved - the tobacco industry, the farmers and the governments - to adjust their tobacco business slowly to other forms of business. There were examples of diversification both at tobacco industry level and at the level of national agriculture. Thus, no economic catastrophe was impending for countries that undertook tobacco control action for health reasons; on the other hand, as a number of delegates had aptly stressed, if nothing were done now to stem the spread of tobacco use, in future much of the gross national products would be wasted on the health and social costs of tobacco-related diseases. In response to the concern that the resolution might appear so regulatory and strongly worded as to prevent realistic implementation in some countries, he pointed out that a Health Assembly resolution did not imply obligation, but provided guidance and was an instrument that national health authorities might wish to use if they wanted to initiate or strengthen tobacco control action. It safeguarded national characteristics and left it to the individual governments to decide how to implement the resolution or parts of it. Finally, he echoed the remark of the delegate of Cuba that health should be the topmost priority in countries.

Dr STJERNSWARD (Cancer) reassured the delegates that since 30% of cancers worldwide were associated with the smoking or chewing of tobacco, tobacco control programmes had long been an integral part of the activities of the WHO cancer control programme, and wherever national cancer control programmes were implemented with the right priorities and strategies in Member States, cancer control through tobacco control was always a priority. If present trends continued, cancer was expected to be a major public health problem in all Member States by the year 2000, due primarily to the ageing of the population and - what was unnecessary, avoidable and preventable - a continued rise in tobacco use.

The need for new priorities and strategies in the field of cancer, even in developed countries, was indicated by the recent publication of WHO data showing that in 28 industrialized countries age-adjusted cancer mortality had increased by 19% in males between 1960 and 1980. The major share of the increase was in lung cancer: 76% for men and 135% for women, confirming the urgent need for action against the use of tobacco.

Oral cancer was a major health problem and in most parts of South-East Asia. Approximately 90% of oral cancers were cause-related to tobacco use. But it could be shown that life-styles could be changed positively by health education. Commitments to include anti-tobacco legislation and information on tobacco and health and coordinated national tobacco control efforts as part of national cancer programmes had been received from a number of Member States.

Dr BOTHIG (Cardiovascular Diseases) said that it was broadly recognized that smoking belonged to the three major risk factors for coronary heart disease, sudden cardiac death, stroke and peripheral arterial disease. The fight against smoking and the promotion of non-smoking had always been an integral part of all WHO cardiovascular activities. The WHO intensified programme for the prevention of coronary heart disease emphasized mass health education and anti-smoking legislation at country level.

The primodial prevention programme, which aimed at the prevention of risk factors in countries where they were not yet prevalent, concentrated especially on inhibiting the onset of smoking in such countries, particularly among young people who had not yet started the habit.

Trends in smoking were being monitored in 27 countries participating in the WHO MONICA project. It was interesting to observe that in most countries with declining cardiovascular disease mortality a decline in smoking prevalence had also occurred.

Some delegates had referred to the issue of low-tar/low-nicotine cigarettes. The reports of all recent expert groups had stated that hopes for the so-called "safe cigarette" had not been confirmed by evidence. Cardiovascular health hazards did not diminish in parallel with the spread of low-tar/low-nicotine cigarettes, because smokers smoked or inhaled more of those products to maintain their accustomed nicotine level. It was still not unequivocally established which factors were responsible for the various ill-effects of cigarettes: nicotine, tar or carbon monoxide. The effect was most probably complex and it was unlikely that elimination or substantial reduction of any single component would solve the problem. That was why cardiovascular disease experts did not advocate a so-called "safe cigarette".

The CHAIRMAN invited the Committee to consider the resolution recommended for its attention in resolution EB77.R5 of the Executive Board.

Dr KHALID BIN SAHAN (Malaysia) agreed that tobacco was dangerous. Those who consumed it should be encouraged to give it up or reduce their consumption, and effective measures should be taken to prevent non-consumers, particularly children and young people, from acquiring the habit. In Malaysia definite steps had been taken in that direction, such as warnings on cigarette packets, banning smoking in cinemas, meeting rooms and hospitals, banning advertising through the public media, and promoting health education. The industry of course had found other ingenious ways of advertising indirectly. Malaysia was already implementing some of the measures advocated in the draft resolution; he did not know whether the others could be achieved within the time targets which had been fixed. The Malaysian delegation would vote in favour of the draft resolution, but with reservations, in particular concerning operative paragraph 4(8), not because it was not convinced that such measures were desirable, but because it was uncertain that they could be implemented within the time frame set by the resolution. Malaysia would nevertheless endeavour to implement as many of the recommendations as were nationally feasible.

Mrs NASCIMBENE DE DUMONT (Argentina) said that her delegation associated itself with the consensus on the draft resolution because Argentina shared the objectives at which the resolution was aimed. Nevertheless, in view of the economic crisis which her country was going through, due in particular to the obligations arising from its enormous foreign debt, and taking account of the great importance of tobacco-growing and the tobacco industry for Argentina's national and regional economy and for the employment of labour, she had to say that the Argentine Government would adapt the pace of implementation of the recommendations contained in the resolution to conditions arising from its economic and social realities.

Dr QUIJANI NAREZO (Mexico) likewise supported the consensus in favour of the draft resolution but wished to place on record that the social and economic implications of the text would have to be taken into account in the conduct of any campaign against tobacco use.

The CHAIRMAN asked if there was a consensus in the Committee in favour of the resolution.

The draft resolution proposed by the Executive Board in resolution EB77.R5 was approved by consensus.

2. GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000: Item 20 of the Agenda (continued)

Economic dimension (consideration of a draft resolution): Item 20.2 of the Agenda (Resolutions WHA38.20, WHA38.21 and EB77.R11; Document A39/4) (continued)

The CHAIRMAN called attention to the draft resolution on the repercussion of the world economic situation proposed by the delegations of Argentina, Bolivia, Cuba, India, Peru and Yugoslavia (A39/A/Conf.Paper No.2 Rev.1), which read:

The Thirty-ninth World Health Assembly,

Bearing in mind resolution WHA38.20;

Recalling that the basic principle stated in the preamble of the Constitution of the World Health Organization that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity";

Recalling further that in the light of the constitutional objective of WHO, the Declaration of Alma-Ata and resolutions WHA30.43, WHA32.30 and WHA33.24, the World Health Assembly approved the Global Strategy for Health for All by the Year 2000 in resolution WHA34.36 and adopted all relevant resolutions on TCDC/ECDC;

Having considered the provisional report of the Director-General on the repercussions of the world economic situation;

Noting that the report, however provisional, recognizes that the widespread economic crisis has resulted in a fall in the living standards in many countries and provoked serious unemployment and formidable austerity policies which in some countries have resulted in a generalized increase of poverty and substantial cuts in health budgets;

Aware that the crisis facing the world economy adversely affecting the developing countries is aggravated by the persistent rise in the foreign debt and the deterioration of the balances of trade, among other factors, and endangers the possibility of reaching the goal of health for all by the year 2000;

Recalling the importance of the New International Economic Order in overcoming the effects of the current economic crisis;

Concerned at the present trends in both multilateral and bilateral external cooperation noted in the report of the Director-General, indicating that the health sector is not given the necessary importance;

1. URGES Member States:

(1) to deploy all their efforts to avoid the reduction in the national budgets provided for health services and health-related activities with a view to achieving the objectives laid down in the Global Strategy for Health for All by the Year 2000;
(2) to develop further their national strategies for health for all by the year 2000, inter alia, by producing costed plans in the most realistic way within the resources expected to be available, in particular focusing on primary health care;
(3) to explore all possible sources of finance, including the redeployment of existing resources;

2. CALLS UPON all developing countries to intensify their efforts for the further promotion of TCDC/ECDC with a view to overcoming the present grave economic situation and thereby contributing inter alia to the implementation of their national strategies for health for all;

3. APPEALS to the developed countries to increase their cooperation with and assistance to developing countries through bilateral and multilateral channels, including WHO, in implementing their health plans;

4. CALLS UPON organizations and agencies for international cooperation to increase their assistance to the national health strategies of developing countries;

5. DRAWS the attention of the international financial organizations to the need to take into account the specific conditions in each particular case as well as to apply criteria of social justice in formulating adjustment policies in order to avoid a deterioration in the health of the people.

6. REQUESTS the Director-General:

(1) to continue to study the repercussions of the economic crisis on health in order to complete the present provisional report and make recommendations to the Fortieth World Health Assembly;
(2) to monitor trends in external cooperation for the health sector of developing countries from all sources and, in this regard, to call upon countries and bilateral donors, nongovernmental organizations and agencies or organizations for multilateral cooperation to increase their support for national health strategies within the general plans for development of the developing countries;
(3) to continue to support countries in their financial planning for health through both technical cooperation and the promotion of training.

Dr KOOP (United States of America) said that it had seemed, on the previous day, that there might be a way to achieve consensus on the text and his delegation might have misled the co-sponsors in that regard, for which he apologized. Today it was clear that his delegation could not accept several provisions of the resolution, in particular the reference in the seventh preambular paragraph to the "New International Economic Order" and the effort in the operative paragraph 5 to instruct the international banks on how to conduct their business. His delegation believed that neither paragraph fell within the proper sphere of responsibility of the Health Assembly. Therefore it had to request a vote on the text and would vote against it.

Dr SAVEL'EV (Union of Soviet Socialist Republics) suggested that in the paragraph referring to the importance of the New International Economic Order mention should be made of United Nations General Assembly resolution 40/173 which recognized the need for action to promote economic security aimed at the economic and social development and progress of each country, in particular developing ones. He suggested that after the words "New International Economic Order" there should be inserted the words "and United Nations General Assembly resolution 40/173".

Mrs NASCIMBENE DE DUMONT (Argentina), on behalf of the co-sponsors, said that they were presenting a revision of their original resolution in a spirit of compromise to meet the concerns expressed by some delegations, and on the understanding that the revised draft resolution could be approved without a vote. Unfortunately that appeared not to be the case; the major problem now lay in the reference to the New International Economic Order. It would be superfluous to insist on the importance of that principle for the developing countries, but it should be pointed out that the language used in the preambular paragraph was extremely moderate, merely recalling the importance of the New International Economic Order without going further. The co-sponsors had really believed it was a text which deserved, if not to win a consensus, at least to pass unopposed. On that same paragraph the Soviet delegation which had already informally submitted its request to her delegation, had reiterated its desire to include a reference to General Assembly resolution 40/173. Her delegation was not unaware of the importance of the subject of that resolution, and the delegation of Argentina along with many others, had voted for it in the General Assembly the previous year. Nevertheless she wished to remind the Soviet delegate of the importance to the co-sponsors and to all the delegations of the developing countries of the principle of the New International Economic Order and therefore appealed to him to withdraw his amendment so that the simple reference to the New International Economic Order as it stood in the draft resolution could stand alone as an expression of that principle, which was deeply felt and dear to the hearts of all the developing countries. For that reason, and because of the moderate language and the spirit animating the resolution, she appealed to all delegations to vote in its favour.

Dr GRANADOS (Cuba) requested, in accordance with the Rules of Procedure of the World Health Assembly, that the vote called for by the delegate of the United States be taken by roll-call.

Mr RUBIO CORREA (Peru) said his delegation fully endorsed the comments of the delegate of Argentina. The texts of the draft resolution, as reconciled in the draft before the Committee, clearly reflected the flexibility shown by the co-sponsors who had carefully listened to the views, comments and suggestions made by the delegates of many countries. He deeply regretted that the delegate of the United States had considered it necessary to ask for a vote on the draft resolution, and he urged the delegate of the Soviet Union to withdraw his amendment.

Dr GEORGIEVSKI (Yugoslavia) said that he wished to associate himself with the comments of the delegate of Argentina. The countries listed as co-sponsors were giving effect to a decision of the health ministers of the non-aligned and other developing countries, who had all given the draft resolution their support. He therefore agreed with the delegate of Peru who had urged the delegate of the Soviet Union to withdraw his amendment. He supported the request made by the delegate of Cuba; a vote should be taken without delay.

Dr SAVEL'EV (Union of Soviet Socialist Republics) said that he could not see his way to withdrawing his proposed amendment, since he failed to see any incompatibility between it and the draft resolution in the light of the fact that the General Assembly resolution also recalled the importance of the New International Economic Order.

Dr ROSDAHL (Denmark) said that he was not familiar with the General Assembly resolution referred to by the delegate of the Soviet Union. He wondered whether a vote should be taken on the Soviet amendment in view of the fact that, in the absence of knowledge of the background, many delegates would be voting in the dark.

Mr DEBRUS (Federal Republic of Germany) said that his delegation was unable to support the draft resolution for two reasons. First, his country, being a federal and not a centralized State, did not have such a thing as a "costed plan", and so operative paragraph 1(2) was unacceptable, unless it was redrafted by inserting the words "whenever feasible" to take his country's constitutional structure into account. The second and major reason was that the draft resolution would seem to confine support to the field of health. That ran counter to his country's economic cooperation policy which was to support projects in response to requests made by developing countries and those projects were not restricted to health. Furthermore, operative paragraphs 1(3) and 2 did not make it clear how future priorities were to be set in the light of existing commitments. In view of limited financial resources available, he felt that the draft resolution should not leave room for doubt on that point. His delegation would therefore abstain.

Dr SAIGAL (India) said that his delegation endorsed the views expressed by the delegates of Argentina and Yugoslavia and appealed to the delegate of the United States to abandon his opposition, and to the delegate of the Soviet Union to withdraw his amendment.

Professor SENAULT (France) said that his delegation had not intended to take the floor if there had been a consensus on the draft resolution, but in view of the wide divergences of opinion, it wished to enter a reservation with regard to the sixth preambular paragraph because of its reference to the debt problem, which had no place in a resolution of the World Health Assembly: he well understood the magnitude of the problem but considered that it should be addressed by other organizations of the United Nations system. He had a greater reservation with regard to operative paragraph 5. However, he did not wish to take up the Committee's time by going into detail. His delegation would abstain.

Dr SAVEL'EV (Union of Soviet Socialist Republics) said that to faciliate reaching a consensus his delegation withdrew its amendment proposing a reference to the General Assembly resolution.

Mrs URQUIJO NUÑO (Nicaragua) recalled what her delegation had already said with regard to item 20. In the debate on that item, the extent of the impact which economic developments and warlike situations had on the health of the people and on progress towards the goal of health for all by the year 2000 had been made clear to all the delegates. It should therefore cause no surprise that reference should be made to foreign debts or warlike situations. She appealed to the delegates to recognize the fact that there were countries whose health goals and programmes were being seriously affected by such developments. That should be clearly spelt out in the draft resolution which her delegation supported.

The CHAIRMAN noted that some countries had reservations on the draft resolution, while others had called for a vote because they did not agree with its text and furthermore amendments had been proposed. He therefore asked the delegate of Argentina whether she accepted the amendment submitted by the delegate of the Federal Republic of Germany.

Mrs NASCIMBENE DE DUMONT (Argentina) said that she understood that the delegate of the Federal Republic of Germany had referred to operative paragraphs 1(2) and 2. She asked for the exact text of his proposed amendment to be repeated.

Dr RAY (Secretary), at the Chairman's request, read out the English text of the amendment to operative paragraph 1(2), which consisted in inserting "whenever feasible" between "producing" and "costed plans". The subparagraph, as amended, woud read: "to develop further their national strategies for health for all by the year 2000, inter alia, by producing, whenever feasible, costed plans in the most realistic way ... ".

Mrs NASCIMBENE DE DUMONT (Argentina) said that she thought she could speak for the other co-sponsors, in saying that there could be no objection to accepting the proposed amendment.

Professor LAFONTAINE (Belgium) said that the situation seemed somewhat confusing and asked whether it might not be possible to vote a little later, so that those who had proposed amendments could consult the co-sponsors and the Committee have a text that was really clear. Otherwise his delegation would have to abstain.

The CHAIRMAN held that the amendments which had been read out were minor and quite clear.

Mrs NASCIMBENE DE DUMONT (Argentina) explained that the text of the draft resolution was contained in document A39/A/Conf.Paper No.2 Rev.1, and that the only amendment had been submitted by the delegate of the Federal Republic of Germany. It concerned operative paragraph 1(2) and consisted of the insertion of the words "whenever feasible" between "by producing" and "costed plans". As the delegate of the Soviet Union had withdrawn his proposed amendment, that was the only amendment and it had been found acceptable.

Professor CISS (Senegal) said that his delegation supported the draft resolution, which was consistent with his country's views with regard to the world economic situation.

The CHAIRMAN said that the time had come to take the vote on the draft resolution, as amended, following the proposal made by the delegate of the Federal Republic of Germany and accepted by the co-sponsors. Voting would be by roll-call, as requested by the delegate of Cuba. He wished, however, to ask him whether he still insisted on a roll-call vote. The vote could be taken by show of hands instead.

Dr GRANADOS (Cuba) maintained his request.

A vote was taken by roll-call, the names of the Member States being called in the French alphabetical order, starting with Egypt, the letter "e" having been determined by lot.

The result of the vote was as follows:

In favour:	Afghanistan, Algeria, Argentina, Austria, Bahrain, Belgium, Bhutan, Brazil, Bulgaria, Burkina Faso, Burundi, China, Colombia, Cook Islands, Costa Rica, Cuba, Cyprus, Czechoslovakia, Denmark, Egypt, Finland, Gambia, German Democratic Republic, Ghana, Greece, Grenada, Guatemala, Guinea, Guyana, Haiti, Hungary, Iceland, India, Indonesia, Iran (Islamic Republic of), Ireland, Jamaica, Jordan, Kenya, Kiribati, Kuwait, Lesotho, Liberia, Madagascar, Malawi, Malaysia, Maldives, Mali, Malta, Mauritania, Mexico, Morocco, Nepal, Nicaragua, Niger, Nigeria, Norway, Papua New Guinea, Peru, Poland, Qatar, Senegal, Sierra Leone, Sri Lanka, Sudan, Suriname, Swaziland, Sweden, Tonga, Trinidad and Tobago, Tunisia, Turkey, Uganda, Union of Soviet Socialist Republics, United Arab Emirates, United Republic of Tanzania, Yugoslavia, Zaire, Zambia.
Against:	United States of America.
Abstaining:	Australia, Canada, France, Germany, Federal Republic of, Israel, Italy, Japan, Luxembourg, Monaco, Netherlands, New Zealand, Portugal, Switzerland, United Kingdom of Great Britain and Northern Ireland.

The draft resolution was therefore approved, as amended, by 79 votes to 1, with 14 absentions.

Mr CAMPBELL (Australia) said that his delegation had abstained in the vote, not because it denied the importance of the nexus between economic developments and health issues in many countries, but because of difficulties which his delegation had with some of the terminology employed in the text of the draft resolution. Specifically, his delegation would have preferred that the references in the sixth preambular paragraph to debt and terms of trade

affecting the developing countries should have been amended so as to refer to "some" developing countries, in order to reflect reality more closely. It was a matter for regret that the formulation in the seventh preambular paragraph did not follow the consensus formulation used in other international forums. Finally, his delegation had some difficulties with the idea implicit in operative paragraph 5 that one of the specialized United Nations agencies might pass resolutions, even of an exhortatory kind, which impinged on the distinct policy responsibilities of other agencies.

Dr CHRISTMAS (New Zealand) said that New Zealand would have liked to vote in favour of the resolution but had been obliged to abstain because of the extraneous insertion of the reference to the "New International Economic Order" in the seventh preambular paragraph. His delegation had similar reservations about operative paragraph 5.

3. INFANT AND YOUNG CHILD NUTRITION (PROGRESS AND EVALUATION REPORT; AND STATUS OF IMPLEMENTATION OF THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES): Item 21 of the Agenda (Resolutions WHA33.32 and WHA37.30; Article 7 of the Code; Documents A39/8 and A39/8 Add.1) (continued)

The CHAIRMAN invited attention to the draft resolution which was submitted by the delegation of Nigeria and sponsored by the delegations of the Bahamas, Botswana, Cameroon, Cuba, Egypt, Guinea-Bissau, Guyana, Indonesia, Islamic Republic of Iran, Lesotho, Liberia, Mauritius, Mozambique, Nigeria, Uganda, United Republic of Tanzania, Uruguay and Yugoslavia. Amendments to the draft resolution had been submitted by Suriname and the Union of Soviet Socialist Republics. The draft resolution read as follows:

> The Thirty-ninth World Health Assembly,
>
> Recalling resolutions WHA27.43, WHA31.47, WHA33.32, WHA35.26 and WHA37.30 which dealt with infant and young child feeding;
>
> Having considered the progress and evaluation report on infant and young child nutrition;
>
> Recognizing that implementation of the International Code of Marketing of Breast-milk Substitutes is a minimum requirement for healthy infant and young child feeding in all countries;
>
> Aware that today, five years after adoption of the International Code, there is an urgent need to strengthen compliance with the Code, and that many products unsuitable for infant feeding are none the less being promoted and used for this purpose;
>
> Noting with great satisfaction the guidelines concerning the main health and socioeconomic circumstances in which infants have to be fed on breast-milk substitutes, in the context of Article 6, paragraph 6, of the International Code, which state, inter alia, that only small quantities of breast-milk substitutes are ordinarily required to meet the needs of a minority of infants in maternity wards and hospitals.
>
> 1. URGES Member States:
>
> (1) to implement the Code if they have not yet done so;
>
> (2) to ensure that the practices and procedures of national health care systems are consistent with the spirit and letter of the International Code;
>
> (3) to make the fullest use of nongovernmental professional and consumer organizations, generally in protecting and promoting breast-feeding and, specifically, in implementing the Code and monitoring compliance with its provisions;
>
> (4) to seek the cooperation of infant food manufacturers and other relevant companies in obtaining the fullest possible data on sales and distribution of products covered by the Code, as well as information on company practices and their compatibility with the Code;
>
> (5) to provide the Director-General with more complete and detailed information on Code implementation;
>
> (6) to use the available information to mean that maternity wards and hospitals should not be recipients of free or subsidized supplies of breast-milk substitutes;

2. REQUESTS the Director-General:

(1) to propose a simplified and standardized reporting form for use by Member States that will allow evaluation of Code implementation article by article;
(2) to disseminate the information that:
(a) any infant food or drink which interferes with the initiation or maintenance of breast-feeding should be considered a breast-milk substitute and should be marketed in accordance with the Code;
(b) after six months, infants are ready for a mixed diet and specially formulated milks (so-called "follow-up" milks) are unnecessary.

Dr RAY (Secretary) said that the amendment proposed by the delegation of Suriname related to operative paragraph 1(6) and read as follows: "To use available information in order that maternity wards and hospitals can make the best use of breast milk substitutes whether they are bought or received as free or subsidized supplies."

The delegation of the Union of Soviet Socialist Republics had proposed two amendments. The first was to introduce a new subparagraph 7 under operative paragraph 1, reading as follows: "To disseminate information widely that any infant food or drink which interferes with the initiation or maintenance of breast-feeding should be marketed in accordance with the Code and that infants of six months or more are ready for a mixed diet without the need for specially formulated milks (so-called follow-up milks)." That proposal took up existing operative paragraph 2(2) and inserted it under operative paragraph 1(7).

The other amendment proposed by the Soviet delegation referred to operative paragraph 2 which would be replaced by the following text: "REQUESTS the Director-General to propose a simplified and standardized evaluation form for use by Member States that would allow monitoring of Code implementation article by article."

Dr SAMSOM (Netherlands) said that the countries of the European Community had some difficulies with the proposed resolution as drafted. He had consulted the delegate of Nigeria with a view to developing a common point of view. The countries of the European Community had prepared a working paper which a drafting group might wish to work on with a view to developing a consensus text.

Professor RANSOME-KUTI (Nigeria) said that he had discussed with the delegation of Suriname that country's proposed amendment to operative paragraph 1(6) and the delegation of Suriname had agreed to withdraw the amendment.

Following a discussion with the delegate of the Soviet Union it had been agreed that paragraph 2(1) should read as follows: "to propose a simplified and standardized evaluation form for use by Member States that will allow monitoring of Code implementation article by article;" and that in paragraph 2(2)(a) the word "considered" should be replaced by "treated as".

With reference to the statement by the delegate of the Netherlands, he had not yet been able to study the text prepared by the European Community group of countries. In his view a small working group would be able to resolve the differences quickly.

Professor CISS (Senegal) said that his delegation wished to become a co-sponsor of the revised draft resolution.

Dr HOPKINS (United States of America) said he would like to see a consensus reached on the text and requested the Chairman to appoint a working group of which his delegation would like to be a member.

The CHAIRMAN announced the establishment of a working group consisting of the delegations of: Algeria, Guatemala, Netherlands, Nigeria, Switzerland, United Kingdom of Great Britain and Northern Ireland and the United States of America, and any others interested.

4. INTERNATIONAL DRINKING WATER SUPPLY AND SANITATION DECADE (MID-DECADE PROGRESS REPORT): Item 24 of the Agenda (Resolution WHA36.13; Documents A39/11 and A39/11 Corr.1)

The CHAIRMAN invited the Committee to proceed to item 24 of it's agenda.

Dr OKWARE (Uganda) thanked the Director-General for his comprehensive and informative report on the International Drinking Water Supply and Sanitation Decade. It was a fact that adequate water supplies and effective sanitary measures could significantly reduce most of the infectious diseases in developing countries. Gastroenteritis, parasitoses and many deadly infectious tropical conditions were directly related to water. Of the many infections related to water in Uganda dracunculiasis was a particularly debilitating disease for which there was no known chemotherapy, so that the worm had to be extracted from the body over several weeks, using a very painful procedure. The provision of safe water supplies dramatically interrupted further transmission of the disease. The geographical distribution of the disease in Uganda was interesting as it was only endemic in two of the northern districts, which were dry and arid and where water was scarce. In those areas prevalence rates as high as 13% had been reported and over two million persons were at risk. Incidence rates peaked during the two dry seasons during which the population, together with the animals, shared the limited water available in the stagnant pools.

The most effective long-term approach to controlling the disease was through the provision of safe water. His Government considered the provision of water to those areas to be a matter of priority and proposed to drill one borehole per 200 persons by 1990. A number of boreholes had already been drilled thanks in large measure to UNICEF which had complemented his country's own efforts most generously.

It was interesting to note that in areas with boreholes the incidence of guinea worm infection had dropped almost to zero. With appropriate health education that happy state of affairs was likely to be maintained.

In Africa the dracunculiasis belt stretched from west to east Africa following the arid areas. The need for international cooperation in the fight against that disease was crucial. His Government realized that fragmented national efforts would be hampered, bearing in mind that there was also much movement across frontiers by nomadic groups.

He had been glad to note that the Regional Office for Africa had addressed itself to that problem. A meeting of affected countries was planned to take place in Niamey during the current year and it was his hope that, following that meeting, appropriate strategies for controlling the disease would be discussed.

It was the view of his delegation that, during the International Drinking Water Supply and Sanitation Decade, plans of action for the control of dracunculiasis should be incorporated in the national plans for health action in a way which was mutually beneficial. Therefore, on behalf of the delegations of Burkina Faso, Cameroon, India, Mauritania, Nigeria, Uganda and the United States of America, his delegation therefore wished to introduce the resolution on elimination of dracunculiasis which read as follows:

The Thirty-ninth World Health Assembly,

Deploring the considerable adverse effects of dracunculiasis (Guinea-worm disease) on health, agriculture, education, and the quality of life in affected areas of Africa and southern Asia, where over 50 million persons still remain at risk of the infection;

Recognizing the special opportunity afforded by the International Drinking Water Supply and Sanitation Decade (1981-1990) to combat dracunculiasis, as noted in resolution WHA34.25;

Stressing the importance of maximizing the benefits to health by using an intersectoral approach in the context of primary health care during the remainder of the Decade;

Aware of the progress achieved to date by the Indian Guinea-worm eradication programme, the increasing awareness and actions beginning to be taken against the disease in Africa, and the successful elimination of the disease in several countries;

1. ENDORSES the goal of eliminating this infection, country by country, in association with the International Drinking Water Supply and Sanitation Decade;

2. ENDORSES a combined strategy of provision of safe drinking-water sources, active surveillance, health education, vector control, and personal prophylaxis, for eliminating the infection;

3. CALLS on all affected Member States:

(1) to establish as quickly as possible, within the context of primary health care, national plans of action for eliminating dracunculiasis, giving high priority to endemic areas in providing safe sources of drinking-water;
(2) to intensify national surveillance of dracunculiasis, and report the resulting information regularly to WHO;

4. INVITES bilateral and international development agencies, private voluntary organizations, foundations, and appropriate regional organizations:

(1) to assist countries' efforts to add, within the context of primary health care, a dracunculiasis control component to ongoing or new water supply, rural development, health education and agricultural programmes in endemic areas by providing required support;
(2) to provide extrabudgetary funds for this effort;

5. URGES the Director-General:

(1) to intensify international surveillance so as to monitor trends in prevalence and incidence of this disease, and encourage cooperation and coordination between adjacent endemic countries;
(2) to submit a report on the status of these activities to the Forty-first World Health Assembly.

Dr KHALID BIN SAHAN (Malaysia) said that the case for adequate water supply and sanitation did not need to be restated. The passage of many resolutions relating to the issue was an expression of universal concern regarding the whole problem of water supply and sanitation and the conditions and diseases associated with them. What was obvious was that a large proportion of the world population, particularly in rural areas and periurban slums, were still without those basic necessities. The consequences of those inadequacies could be clearly seen from the higher morbidity and mortality rates of the affected population.

He thanked the Director-General for a most informative and comprehensive mid-Decade review of the Decade programme. There appeared to be a likelihood that, in many countries, the target for the Decade would not be achieved. The disparities in service between urban and rural areas continued and the imbalance between water supply and sanitation persisted. The reasons for those inadequacies and weaknesses were well explained in the Director-General's report.

His delegation agreed with and supported the recommendations contained in the report. Together with the delegations of Australia, Burkina Faso, Chile, China, New Zealand, Peru and Turkey, his delegation was co-sponsoring a resolution entitled "International Drinking Water Supply and Sanitation Decade".

The draft resolution addressed itself to the issues and concerns raised in the Director-General's report. If accepted, the resolution would further strengthen the implementation of the Decade programme and would, it was hoped, effectively accelerate the achievement of the Decade's target.

The draft resolution was intentionally broad-based and was aimed at the total problem of water supply and sanitation per se, rather than linking it with any specific health problem. The sponsors had purposely avoided quoting health reasons for upgrading water supply and sanitation for three reasons, namely: good water supply and sanitation constituted basic needs which should not require a health justification for their provision; health problems differed from one country to another, so that to justify the improvement of water supply and sanitation by the existence of certain specific disease conditions might not be universally valid or acceptable; and, linking the Decade programme to specific disease conditions might weaken the current commitment and narrow its goal and scope. Inadequate water supply and sanitation were serious problems in themselves and demanded urgent solutions in their own right. The draft resolution was therefore submitted to the Committee for its consideration. It read as follows:

The Thirty-ninth World Health Assembly,

Noting with appreciation the report of the Director-General on the International Drinking Water Supply and Sanitation Decade: mid-Decade progress review;

Recalling the recommendations in resolution WHA36.13 and particularly its recognition that safe drinking-water supply and sanitation are essential for the success of the Global Strategy for Health for All;

Noting that progress with the Decade programme so far has fallen short of expectations in spite of the considerable efforts by Member States to improve water supply and sanitation services since it began;

Noting further that, if present trends continue, many countries will not meet the targets they have set;

Endorsing the recommendations in the Director-General's report for the more active participation of national health authorities in water supply and sanitation programmes through intersectoral collaboration and for the continued effective cooperation of the external support agencies involved,

1. CALLS for more determined efforts during the second half of the Decade, so that the Decade targets which Member States have established can be achieved;

2. URGES Member States:

(1) to reduce imbalances in levels and quality of service between urban and rural areas and between water supply and sanitation;
(2) to ensure that the national health authorities include support to water supply and sanitation programmes among their primary health care activities;
(3) to ensure intersectoral collaboration among national and international agencies with operational responsibility for and/or involvement in water supply and sanitation and other agencies;
(4) to seek and support ways in which resources can be increased through the fullest possible participation of consumers in meeting programme costs;
(5) to provide for adequate operation and maintenance, as well as rehabilitation and surveillance, to ensure satisfactory services;

3. URGES external support agencies:

(1) to continue the high priority given to water supply and sanitation and increase the proportion of resources made available for underserved populations and poor areas;
(2) to increase likewise the proportion of resources allocated for institutional and human resources development, operation, maintenance and rehabilitation, public information, health and hygiene education, and community participation;
(3) to continue their efforts to improve their coordination and exchange of programme information at country and international levels with the national and other external agencies concerned;

4. REQUESTS the Director-General:

(1) to implement the proposals contained in his mid-Decade report, giving particular emphasis to the fullest possible advocacy of health, intersectoral action, coordination with other organizations of the external support community, and increased involvement of the national health authorities in the development of water supply and sanitation;
(2) to continue to monitor progress in water supply and sanitation and support Member States in strengthening their own monitoring systems as part of management;
(3) to submit an interim progress report on Decade implementation as part of the second evaluation of the Global Strategy for Health for All by the Year 2000 and to report to the Forty-fifth World Health Assembly in 1992 following the conclusion of the Decade.

Professor SHERIF ABBAS (Somalia) said that his delegation approved the Director-General's report. In Somalia the scarcity of dependable water supplies for the rural population and their livestock was the most serious constraint to economic development. From the economic point of view, the quantity of water available in the rural areas was insufficient during the wet season and often so small as to be life-threatening during the dry season. Approximately 20% of the rural population had reasonable access to standpipes and wells that produced safe water; the rest of the population was dependent upon surface water ponds. During the dry season, the majority of those ponds dried up. During the wet season, water used per capita seemed to be about 12 to 15 litres; according to a recent report, during that period women spent two to four hours a day in procuring water. There was adequate water to bathe children daily and wash clothes weekly. During the dry season, water used per capita decreased to a life-threatening 3 litres per day and women reported spending up to eight hours fetching water. The watering of household livestock, often the responsibility of women and children, would sometimes take up to 12 hours. In such conditions, children and women suffered tremendous stress.

The Ministry of Water and Mineral Resources was responsible for policy, long-term national planning and water research. Under that body, several semi-autonomous agencies and a national committee divided the responsibilities for actual implementation. The national water committee was responsible for all decisions concerning placement of the always scarce new water resources and met once a year for that task. The national health plan acknowledged that the availability of safe drinking-water in Somalia was the number one environmental health problem. The Government had subscribed to the objectives of the Decade and had accordingly attributed high priority to the sector in the country's overall planning context. The Government intended to place particular stress on rural and urban-fringe water supplies complemented by countrywide sanitation facilities. The concept was to develop those areas with low cost, appropriately designed and easily replicable installations. Another goal was to intensify health education and the maintenance of existing, and the development of new, schemes, mainly by strengthening the institutional infrastructure of the sector.

Somalia had defined its objectives for water supply and sanitation by service and, in the case of drinking-water, by daily per capita consumption. The Decade plan envisaged the following targets which were considered realistic in terms of coverage by the year 1990: 80% in urban water supply; 50% in rural water supply; 40% in urban sanitation; and 25% in rural sanitation. Another objective was to provide each rural and nomad inhabitant with 25 litres per day of safe drinking-water by 1990. Service was considered adequate if the source was not more than 500 metres from a dwelling.

Diarrhoeal diseases and parasitic and viral infections were highly prevalent in most rural areas of Somalia, particularly among children. In many villages, existing water sources were contaminated or had developed high levels of salinity. Other sources provided only low volumes of water due to inappropriate pumping equipment, breakdowns or fuel shortages. By improving water sources and providing education on sanitation awareness in combination with primary health care, it was expected that there would be a general improvement in the health status of the target communities.

The overall objectives of water and sanitation were: (1) to improve the health of children and mothers by reducing the prevalence of diseases relating to poor supply and sanitation; (2) to promote low cost technology for the development of water supply and sanitation systems; (3) to develop, in cooperation with the primary health care system, health education strategies aimed at increasing the awareness of communities about the advantages of improved water supply and sanitation; and (4) to promote the active participation of rural communities in the planning and maintenance of their own water supply and sanitation facilities.

Professor SENAULT (France) expressed his delegation's satisfaction with the Director-General's report. It welcomed the wide commitment of WHO to the International Drinking Water Supply and Sanitation Decade. The Director-General's mid-Decade report showed that there had been some improvement, but it was not sufficient and a greater effort must be made. The proposal that WHO should give a new impetus to the Decade, defining the priorities for action, was therefore fully justified.

In France steps had been taken over the past century to supply drinking-water and sanitation to the population but improvements were still possible. Since 1980 measures had been introduced not only in line with WHO suggestions, but also in implementation of European Economic Community directives. His delegation felt that the suggestions contained in the report should be given due consideration. In particular, it was important to develop close cooperation between health and water authorities, so that together they could develop the arguments based on actual local situations that could help these decision-makers with the difficult decisions, involving large capital investment, that water supply and sanitation required. Through health education everyone should become aware that water was very important and that it should be supplied in the best conditions. He announced that an international meeting was to be held in France in 1987 in cooperation with the Regional Office for Europe at which methods for meeting the general objectives of WHO in the field of water supply would be investigated from technical, resource management, financing and participation points of view.

In conclusion, he would like the Organization to make a study of accidental pollution that might influence the quantity of water available, so that it could advise Member States that might be faced with such situations.

Dr SADRIZADEH (Iran) said that the provision of safe drinking water together with sanitation should be regarded as the most effective method for the prevention and control of diarrhoea and diarrhoea-associated malnutrition. Although the initiation of the Decade had encouraged most countries of the world to establish realistic targets and develop and

implement water supply and sanitation strategies satisfactorily, water supply and sanitation in rural areas was still much worse than in urban areas and the deficiencies in sanitation were even more serious than those in water supply.

In Iran, despite budgetary constraints, high priority had been given to the provision of safe drinking-water in rural areas. An annual budget equivalent to US$ 150 million had been allocated for rural water supply as a result of which safe drinking-water had been provided for more than 55% of the rural population. Nevertheless, hard work was required to reach the target of water supply for 90% of the rural population by 1990, while the sanitation target would call for even greater effort.

Dr HEDAYETULLAH (Bangladesh) said that the provision of pure drinking-water and basic sanitation was one of the eight basic elements of primary health care enumerated in the Alma-Ata Declaration. Some countries had improved their water supply system by the use of tube-wells, but progress in the sanitation component was very poor. Bangladesh had made progress in supplying good quality water to some 70% of the rural population by means of tube-wells. In the sanitation sector only 3% of the population had been provided with water-seal latrines. The tube-well programme was meeting difficulties due to the rapid fall of the ground water level owing to the acute shortage of water during the dry season and continuous use of water for irrigation and drinking purposes. The tube-well water in the southern region of Bangladesh, near the Bay of Bengal, was brackish and undrinkable. Drinking-water was available at a depth of 8000 metres and more which made its exploitation highly expensive and not at all cost effective. The population of those areas had no drinking-water and consequently consumed polluted water from rivers and ponds, resulting in high prevalence of gastrointestinal diseases. He requested WHO to carry out an in-depth study with assistance from UNICEF to provide guidance to his country on solving the problem of supplying drinking-water to millions of people in Bangladesh.

With regard to the progress of the water-seal latrine programme in Bangladesh, UNICEF support needed supplementing by increased allocations from donor countries. He appealed for WHO's catalytic role in improving the water supply and basic sanitation of Bangladesh to be enhanced with a view to improving the health status of the people and achieving health for all by the year 2000.

Dr HOPKINS (United States of America) said that the objectives of the Decade were concerned with a key component of primary health care, namely the prevention of water and water-borne diseases and constituted an important step along the road to health for all. He wished to thank the Director-General and his staff for the report which, he knew, had clearly entailed considerable effort.

His Government had supported the International Drinking Water Supply and Sanitation Decade from its inception with its objective of bringing safe drinking-water and adequate sanitation to all the people of the world. Projects concerned with water and sanitation valued at approximately US$ 2.600 million were currently being supported by the United States Agency for International Development at a rate of US$ 250 million per year. The modest progress reported in what was an important aspect of primary health care was welcome although it was uneven. It was clear however that most areas were very far from where they should be at the mid-Decade, and that the original objectives of the Decade were not going to be attained in most countries. The disappointing under-achievement so far must raise questions for the national and international participants in the Decade, including WHO. Just as the need for the redoubling of effort in order to meet the 1990 goals of the Expanded Programme on Immunization had been recognized and appropriate additional measures were being taken, so there was a need in his view to reconsider urgently what objectives could, and what could not, be attained during the remaining four and a half years of the Decade.

His delegation wished to urge again that more attention be paid to monitoring the impact on health of water and sanitation services, as suggested in resolutions WHA34.25 and WHA36.13. Far too little was said in the mid-Decade report about the health benefits and impact, which had occurred or were expected to occur, as a result of the Decade. Documenting health benefits and serving as an advocate for them should be a key role for WHO and national health agencies. For example, how successful had countries been in maximizing the health benefits of their efforts? How did those efforts relate to WHO's action to help in the control of diarrhoeal diseases, schistosomiasis or dracunculiasis, for example?

Furthermore, nothing was said in the report about the status of associated efforts against dracunculiasis, the one disease whose elimination had been specifically endorsed as a sub-goal of the Decade by the Steering Committee of the Decade at its meeting in Geneva in April 1981. The gradual elimination of that disease country by country was also a specific target of WHO's global medium term programme for parasitic diseases, 1984-1989. Eliminating

the disease which directly affected health, agriculture and education exemplified many key aspects of the Decade; intersectoral coordination, promotion of equity for the rural poor, health education, community mobilization, and maximization of health benefits from activities in non-health sectors. Several successes could be reported, such as the progress of India's guinea worm eradication programme and increasing mobilization of effort in several African countries. A regional meeting of affected African countries was to be held in Niamey, in July 1986, under the auspices of WHO, with additional funding from the Carnegie Corporation of New York, the United States Agency for International Development and the "USA for Africa" Foundation. The Decade sub-goal concerning dracunculiasis should be pursued more actively. Dracunculiasis was endemic in less than 10% of the target communities still unserved by safe drinking-water supplies. The same logic which had wisely led WHO to advocate control of onchocerciasis in West Africa, as an important contribution to the health and economic development of that region, also applied to dracunculiasis in the areas where it occurred, although an effective attack on that disease would be less costly and yield more rapid results even than the successful onchocerciasis control programme. The proposed resolution on the elimination of dracunculiasis would lead to action which would strengthen, not weaken, WHO's leadership in the health aspects of the final four-and-a-half years of the Decade. Health needs varied from country to country and the Organization should not limit itself to diseases which affected all countries. Dracunculiasis affected three regions and was certainly an important disease.

Miss SHAW (New Zealand) said that the provision of safe water and adequate sanitation was essential for the health protection of the community. The recognition of that fact was the reason for the inclusion of safe water and sanitation as one of the eight essential elements of primary health care. However, because those services were so basic to human health they could be overlooked or given insufficient emphasis when national health plans were formulated. Furthermore, when funds were short, local public health engineering projects providing for adequate or better water supplies or safer sewage disposal might be deferred. Safe water and adequate sanitation were major factors in the prevention of diarrhoeal diseases and associated health and human problems. For that reason the New Zealand delegation supported all efforts to promote even more active participation by national health authorities in water supply and sanitation programmes during the Decade.

Dr TULCHINSKY (Israel) welcomed the Director-General's report. Israel had worked very hard to expand its agriculture with a very limited water supply. It was now actively engaged in recycling wastewater for suitable agricultural products and improving irrigation systems by, for example, the drip method as well as by new methods of using brackish water. The relevant information was available for use elsewhere.

His Government was very interested in water quality and he agreed with the delegate of France. Water quality assurance called for continuous review. His Government was very interested in the debate on preventive chlorination, as a standard method of preventing both primary and secondary water contamination. Water-borne disease still existed periodically in Israel and it was felt that to combat it higher standards for water, involving residual chlorine, were required. He urged WHO to look into that question as even the relatively developed countries needed to review their water safety standards. Preventive medicine demanded the pasteurization of milk; it should also require the chlorination of community water supplies. Since that was still a matter of professional controversy, a review of the subject with recommendations by WHO would be helpful.

Dr GRANADOS (Cuba) expressed his appreciation of the high quality of the information contained in the Director-General's report, the analysis of trends and the proposals for action by Member States, external support agencies and WHO. As the report indicated, there had been achievements in the first part of the Decade in supplying water and sanitation for urban and rural communities, thanks to the willingness of the various countries to adopt primary health care as the key to the achievement of health for all by the year 2000. In Cuba, at the time of the revolution, only 112 of 300 urban centres with more than one thousand inhabitants had a water supply and 12 had sewerage. Water supply and sanitation had been increased since that date in urban and rural areas and, by 1984, 70.5% of the total population had a water supply and 40% had sewerage. A programme of water supply and sanitation in rural areas was being implemented with the assistance of UNICEF covering 277 communities; work in 164 of them had been completed in 1985. In addition, an environmental health programme was in progress including health monitoring and epidemiological surveillance of those services, the training of personnel and operational research, supported by health legislation constantly kept up to date.

The results achieved so far in the Decade were a faithful reflection of the repercussions of the economic situation and the ability of Member States to mobilize community resources. It was difficult to give a precise forecast of the world situation at the end of the Decade; but it was clear that, to improve water supply and sanitation for the world's population, financial resources were essential and they could only be made available through the establishment of a new and more just international economic order and the achievement of a climate of peace.

Mr CHENITI (Tunisia) said that it was disappointing to see, from the achievements of the first five years, that the objectives of the Decade were so far from being attained for want of financial and human resources. He wished however to reassure Members regarding Tunisia's policy in that respect. The Tunisian Government had decided to allocate during the first half of the Decade a sum equal to six times the amount available under the fifth plan (1975-1980) for the supply of water to rural areas. A national plan was in preparation for water supply and sanitation in rural areas with the assistance of UNDP and WHO.

He proposed that paragraph 4(2) of the draft resolution on the International Drinking Water Supply and Sanitation Decade be amended to the effect that the Director-General should continue to monitor progress in water supply and sanitation and support Member States in establishing national master plans defining operational strategies for investment and management: (a) to promote research leading to a better knowledge of health indicators for waterborne diseases and analyse the correlation between water quality and health indicators; and (b) to encourage operational research and the promotion of appropriate technology for the water supply and sanitation, particularly in rural areas.

Mr GIANNICO (Italy) commended the Director-General on his report. The problem had different aspects from the viewpoint of quantity and quality depending on whether the countries concerned were developing or industrialized.

The absence of drinking-water produced not only problems of hygiene, but also communicable diseases particularly affecting children and the more vulnerable population groups. Such problems had occurred in Italy in certain regions and especially in the south. Measures taken to improve the distribution of drinking-water had resulted in better health and hygiene for the population. His delegation was therefore very sensitive to the need for concerted international action in the Decade programme, which was an important component of Italian development cooperation programmes. Italy was ready to collaborate fully, at the technical and economic level, to achieve the objects of the Decade.

Dr MARTTILA (Finland) said that a national action committee on the Decade had been established in Finland in 1980. The promotion of research on the quality of drinking-water, the improvement of water quality and the development of water supply and sanitation in rural areas had been set as primary national targets. By the beginning of the current decade 70% of the population of Finland were served by public water supplies; by the mid-1980s that proportion had risen to 75%. The proportion of the population served by house-connection to public sewerage was of the same magnitude. The relatively high proportion of the population remaining out of reach of the public services was due to the low population density in Finland. Owing to the long distances between households in rural areas access to those public services would be extremely expensive if extended to all. In those circumstances, however, public services had not been the only method of safeguarding the quality of drinking-water and supplying adequate sanitation; most of the population beyond the reach of public services had a private piped water and sewage system. A central national target was to ensure piped drinking-water of as good a quality as that distributed by the public waterworks. Another was adequate sewage disposal for all rural inhabitants by 1995. That did not necessarily mean by means of public services. Due to the low population density and the relatively low level of industrial pollution ground-water in Finland was of good quality and most private ground-water wells provided excellent drinking-water to the consumers. Consequently, drinking-water from private wells would still offer a good alternative provided that sewage and waste disposal were arranged and that the general programme for preventing pollution of ground-water was successful. In the special circumstances of Finland the availability of public water supply and sanitation would not therefore be a true indicator of the achievements of the Decade.

Even in Finland cooperation between those responsible for water supply and sanitation and those responsible for primary health care should be promoted in order to reach the targets of the Decade. Although health considerations had been the starting-point of organized water supply and sanitation, there had been, in the background a period of intensive technical development during the 1960s and 1970s. The institution of the Decade

with its targets had revised the original concept of the significance of safe drinking-water and sanitation for human health even in countries where it was thought that the problem had been solved already.

Finland had supported water supply and sanitation projects in several developing countries since 1974. In joint efforts with developing countries it had become convinced that successful water and sanitation projects must be implemented in cooperation with local primary health care personnel.

Mrs URQUIJO NUÑO (Nicaragua) said that her delegation had greatly appreciated the Director-General's report and that its content had been analysed with keen interest, particularly paragraphs 9, 10.4, 11 and 12. Her delegation had been pleased to note progress in developing plans and programmes, the definition of targets by concerned institutions, an improved definition of priorities and an increased awareness of problems related to water and sanitation in most countries, leading to a search for appropriate technology, institutional development for improved administrative and technical management and the focus on optimizing existing systems. The most striking progress made so far had been in drinking-water supply in urban areas, but much remained to be done in rural areas. The situation regarding sanitation remained dramatic in both rural and urban areas.

External and internal funding had failed to come up to expectations, mainly owing to the difficulty, as a result of the global economic situation and the indebtedness of many Third World countries, of access to credit which was further complicated by inflexible bureaucratic procedures. If those problems persisted, they would prevent targets from being reached.

Paragraphs 46, 47 and 49 of the report, summarizing the action required, were specifically focused upon that issue, and had emphasized the need for increased funding and more flexible procedures. Horizontal intrasectoral cooperation would also be extremely important.

The situation in Nicaragua for the most part accorded with the picture given in the report and was, in addition, adversely affected by the military and economic aggression now being directed against that country, which had made it even more difficult for it to obtain credit and to carry out projects as planned. If those conditions persisted, it would be very difficult to attain the Decade targets.

Dr KABORE (Burkina Faso) gave a brief presentation of two social repercussions of his Government's efforts during the first half of the Decade. The drilling of wells had made a great deal of difference to village women who had previously been obliged to cover long distances to obtain water that was often not fit for drinking and who now had more time for other activities. In addition, the Decade had not only brought drinking-water to the people but had also served as a point of departure for a significant health education campaign.

While it was difficult to evaluate the impact upon health at the present stage, those positive social results were so important that current efforts should most certainly be continued and intensified.

Dr UNSAL (Turkey) said that his delegation had been most impressed with the Director-General's report.

His Government had been making every effort to reduce the rate of infant mortality in Turkey and, to that end, had decided to increase its efforts relating to immunization, oral rehydration therapy, nutrition (including breast-feeding) and family planning. Key aspects of those activities were: the training of health personnel, the completion of cold chain and other requirements, health education and intersectoral collaboration. Additional programmes were to be implemented in the course of 1986.

The implementation of these policies had been greatly enhanced by the enthusiastic participation of concerned parties at all levels, and it was hoped that that enthusiasm would be maintained into the future.

Visible health problems were, however, no more than the tip of the iceberg and underlying factors were in fact of paramount importance. Among them were the shortage of safe drinking-water and inadequate sanitation, particularly in the shanty town areas surrounding major towns and cities. In an attempt to come to grips with that problem, a mass housing fund had been created and was being financed from taxes on, for example, fuel, State monopoly goods, and travel abroad. In addition, a development and support fund provided financing to municipalities wishing to buy land and to provide the required infrastructure for mass housing. Mass housing projects in the three largest cities had also benefited from generous assistance from Saudi Arabia and the Council of Europe, as well as the national budget.

The situation in the countryside had also given rise to concern, as no more than 62% of the rural population had access to safe drinking-water, and relatively few rural areas had adequate sewerage systems. A national coordination committee had been established to identify the main problems affecting country people. The Government hoped to develop a national drinking-water supply and sanitation plan to provide safe water to all human settlements by the end of 1990 and to make significant progress in the field of sanitation.

It was difficult to finance infrastructure services continuously from the national budget, and that implied a need to strengthen the finances of local authorities and raise water rates to a realistic level. Current efforts were already yielding significant results, and it was hoped that, by the year 2000, decisive progress would have been made towards health for all.

Dr AYOUB (Egypt) commended the Director-General's most interesting mid-Decade report. At the beginning of the Decade, 88% of the urban population and 69% of the rural population did not have guaranteed access to a supply of safe drinking-water. Those percentages had subsequently been reduced, particularly in urban areas, but a great deal had still to be done - particularly regarding the related issue of sanitation.

The Egyptian Government had now finalized a programme for drinking-water supplies and sanitation, and had set up a national council to implement it throughout the country. Initial and in-service training of field workers was being provided with government assistance and with the help of several international organizations and agencies. The role of women was also receiving attention, as they made a crucial contribution to family living standards and health. Intersectoral cooperation would be of prime importance to the attainment of objectives for the second half of the Decade.

Dr HABIB (Afghanistan) thanked the Director-General for his comprehensive and informative report. He said that his Government's national plan and targets for the Decade bore witness to the high priority given to the provision of safe drinking-water and the improvement of sanitation, as strategies for improving public health. In 1980, less than 25% of the urban population and less than 8% of the rural population had had access to safe drinking-water. That situation had been improved, and a significant training effort had been made to that end. The public's awareness of the issue had been enhanced and community involvement had noticeably increased. However, financial constraints and the current international situation had had an adverse impact upon the Government's ability to meet its objectives, particularly in rural areas. The plan would have to be reviewed and management upgraded to achieve optimum coverage. International assistance would be crucial and continued cooperation by WHO would be of prime importance. His delegation appealed to WHO to continue cooperating with the national health authorities in strengthening their efforts to achieve Decade goals and also to facilitate the mobilization of international resources from other support agencies. He gave his full support to the draft resolution on the Decade.

Dr THAN SEIN (Burma) expressed his delegation's appreciation of the Director-General's report and said that his country's objective was to provide reasonable access to a safe water supply and proper sanitation facilities to 50% of the population by the year 1990, and to achieve full coverage by the end of the century. Success to date had depended upon the use of appropriate technology taking due account of local conditions, and the promotion of community participation through health education campaigns.

The health sector would not be able to implement that policy on its own; it depended on the cooperation of other government agencies. An intersectoral committee had been formed and responsibilities had been assigned to each sector.

Two million town dwellers and 12 million rural people had already been provided with reasonable access to safe water, while 4 million country people had been given access to proper sanitation facilities. Input from WHO, UNICEF, the Australian Government and other agencies had been invaluable in attaining those satisfactory results. The Government hoped to achieve equally satisfactory results in the second half of the Decade, provided that the basic preconditions of successful implementation could be met by all the parties concerned.

Dr EL GADDAL (Sudan) thanked the Director-General for his report and gave a brief presentation of his country's Blue Nile health project, aimed at the control of water-associated diseases, such as malaria, schistosomiasis and diarrhoeal diseases. Among the project's main strategies was the provision of safe drinking-water and the improvement of sanitation in participating villages.

Villagers participated in the cost of constructing pit latrines and of setting up a water supply system, normally either a shallow well with a hand pump or a horizontal flow roughening slow sand filter (a successful modification of the filtering device used previously). Both diarrhoeal diseases and schistosomiasis had become less prevalent as a result of those efforts. His Government was most grateful to USAID, WFP, ODA and UNEP for providing assistance to the project, and was particularly mindful of the invaluable assistance afforded by the Regional Director and the headquarters Parasitic Diseases unit. His delegation wished to co-sponsor the draft resolution on the Decade.

Dr VALLEJO ESPINOZA (Peru) said that his delegation had been struck by the high standard of the Director-General's report, which gave a detailed presentation of problems relating to drinking-water and the environment.

In Peru, a developing country, malnutrition and environmental problems were of paramount importance. The provision of a drinking-water supply and sewerage system were basic to any policy on the environment and, for that reason, the Government had taken steps to meet the challenge of the Decade. The situation was very different in urban, as opposed to rural areas, and it did seem as though it would be very difficult to reach planned targets by the end of the Decade.

Among the factors responsible for that regrettable situation were the low priority given to basic health plans, inadequate resource allocations, a lack of support by national institutions, unduly high fees for administrative services and a shortage of trained manpower at all levels. Those factors had combined to impede progress and needed overcoming if more satisfactory progress was to be made. That was why Peru was co-sponsoring the draft resolution on the Decade.

Given the crucial impact of the physical environment upon public health, government policy was now focused upon improving the quality of life for people living in towns and in the country - in particular, by providing drinking-water supplies and sewerage systems, within the framework of both housing and agrarian policies. A basic sanitation plan had been developed in 1984 and had been updated for implementation in 1986-1995. It was aimed primarily at low income families and gave priority to basic public health measures - which would hopefully include measures adapted to the Andean regions and to urban "twilight zones" - while implying a need to seek the greatest possible return from a minimum outlay. In particular, Peru had designed and set up a simple easily constructed low-cost, water supply system equipment, which could be made available to other interested parties.

The Director-General and his staff were to be congratulated on an excellent report, to which his delegation gave its fullest support.

Dr FIKRI-BENBRAHIM (Morocco) expressed his delegation's appreciation of the Director-General's most interesting report, and emphasized that it would be advisable to review the criteria employed when effecting financial analyses of projects in the light of the results obtained to date. At the same time, activities related to drinking-water and sanitation should be further integrated into primary health care projects.

It did seem as though, in the second half of the Decade, greater emphasis should be laid upon sanitation facilities, as compared with drinking-water supply, which had perhaps been given an undue priority. Ministries of health should, moreover, take steps to achieve an improved coordination of efforts at different levels within each country.

In conclusion, his delegation asked for Morocco to be listed among the co-sponsors of the draft resolution on the Decade.

The meeting rose at 17h20.

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