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PROVISIONAL SUMMARY RECORD OF THE THIRD MEETING

Palais des Nations, Geneva
Wednesday, 4 May 1994, at 9h45

Chairman: Mr A. VAN DAELE (Belgium)

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THIRD MEETING

Wednesday, 4 May 1994, at 9h45

Chairman: Mr D. VAN DAELE (Belgium)

1. IMPLEMENTATION OF RESOLUTIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 19 of the Agenda

Improving technical cooperation among developing countries (Resolution WHA43.9; Document A47/4)

Professor MBEDE (representative of the Executive Board), introducing the item, said that the Director-General's report (document A47/4) took into account the Interregional Consultation on TCDC Programming in Health held in Jakarta from 8 to 12 February 1993, which had formulated an approach of full integration of technical cooperation among developing countries (TCDC) in all health-for-all activities undertaken by the developing countries and encouraged closer cooperation between WHO, UNDP and other international organizations on TCDC. The report noted that the TCDC situation differed from one WHO region to another, as some contained both developed and developing countries. Accordingly, some regions preferred to use the term "Technical Cooperation between Countries (TCC) within the spirit of TCDC". During the Executive Board's discussion of the report, several members had stressed the importance of TCDC and hoped that more use would be made of it.

Remedies had to be found for the slow rate of progress in the health field, which was partly due to a lack of adequate methodologies. The Board would have liked greater emphasis to be placed on the aims of TCDC, on its effectiveness in enhancing local capacity and on the means by which it could lead to changes at a reasonable cost. The Board had stressed that, although the necessary funding must come from the countries themselves, the international community and development agencies should more clearly recognize the value of TCDC. Closer links with UNDP had been requested, especially at country level.

The Executive Board's discussions had led to several amendments to conclusions and recommendations in section V of the report, which now stressed that TCDC was an important tool for ensuring sustainable development and strengthening national capacities and highlighted the need to institute methods for improving use of TCDC and subsequent assessment of results.

In taking note of the report, the Assembly might wish to encourage the measures advocated in section VI.

Dr MUKHERJEE (India) noted that, according to the Director-General's report, the underlying principle that the initiative and responsibility for TCDC must come from the countries themselves was not adequately understood; nor was the potential of TCDC for health development. A meeting of health ministers of the South-East Asia Region, held in Dhaka in November 1993, had discussed those issues in detail and recognized that political commitment was essential to ensure benefit to all cooperating sides. The ministers had also recognized that TCDC in the field of health should not take a narrow view but had to consider many factors that contributed to health and could play an important catalytic role - for instance, safe water and food, and nutrition.

India was an ardent supporter of TCDC and undertook a number of important bilateral and multilateral TCDC activities as well as having operated its technical and economic cooperation programme since 1964. The main obstacle to implementation of TCDC was the paucity of financial resources and delay in planning of activities. India was already doing its best to provide support for other countries within its limited resources, and he urged that international organizations and the developed countries extended their financial support by constituting committees of experts in the various fields concerned.

Professor WANG Yifei (China), expressed his appreciation of the concise document with its useful suggestions for improving TCDC, a major element and catalyst for development in developing countries through the sharing of resources. Since 1978, WHO had done a great deal of effective work in coordinating

and supporting developing countries to conduct interregional and intercountry technical cooperation by establishing focal points, implementing cooperation programmes and providing fellowships. Nevertheless, as the report noted, many problems still existed in the implementation of TCDC and some areas needed urgent improvement. He therefore fully supported the conclusions and recommendations in the report.

Mr KIM Won Ho (Democratic People's Republic of Korea) said that TCDC was one of the means by which developing countries could achieve individual and collective self-reliance and was an important tool for sustainable health development and the building up of institutional capacity in developing countries. It was therefore very important that TCDC should continue and be extended and he hoped that WHO would increase its support for it and encourage the development of mechanisms for more effective use and evaluation of such cooperation.

Dr AVILA DIAZ (Cuba) said that TCDC was of vital importance not only for countries facing difficulties in developing health programmes but also for WHO in achieving its health targets for all countries in a world that was growing poorer despite scientific and technical progress. The special characteristics of each region had to be taken into account and each country had to have the necessary determination to ensure that all resources were used to meet requirements. Experience had to be extended and exchanged with other countries in the region. His country had agreements with other groups and countries to pool experience and focus on common interests in the health sector with a view to mutual support in solving problems, leading to closer relationships in facing numerous difficulties.

As stated in the document, financial resources were not always adequate to meet countries' needs and were not always allocated in the most effective way. Hence, most countries encountered major financial problems, and he considered it very important to identify further funding sources and create the relevant mechanisms for obtaining funds. It must be remembered, however, that the main financial responsibility lay with the countries themselves. He thanked WHO and countries which had contributed resources of all kinds to TCDC.

Mr OCHOA (Colombia), noting the lack of appropriate methods for cooperation between countries, stressed that his country considered there to be four essentials: governments must have the political will, implying mutual trust between the parties; needs and existing capacity in countries had to be identified; the role of the international organizations had to be clearly established, and particularly the catalysing and financial support function of WHO; and, finally, cooperation programmes must constitute an integral part of each country's regular plans and programmes on health matters.

Dr VAN ETTEN (Netherlands) suggested that, in view of the important role played in TCDC by health research, the words "including health research plans" should be added after "health development plans" at the end of the first subparagraph in paragraph 50 of the report, which he supported.

Dr MEREDITH (United Kingdom of Great Britain and Northern Ireland) said that although the report had been revised since the Executive Board meeting in January he felt that it still needed to focus more on measurement of the effectiveness of technical cooperation in helping to improve local capacity. It was important that TCDC led to change that was both affordable and relevant to countries' needs.

Mrs ODUORI (Kenya) commended the Director-General on his concise and comprehensive report and fully supported its conclusions and recommendations. She noted with appreciation the role played by WHO in mobilizing financial and technical resources for TCDC and, aware of the serious economic hardships besetting many developing countries, she urged the Organization to continue and consolidate its efforts to support technical cooperation among developing countries' institutions at intercountry and regional level.

Finally, she reaffirmed her country's commitment to the spirit of technical cooperation.

Dr GEORGE (Gambia) said that TCDC allowed for unique collaboration between developing countries which often shared the same health problems and could be very valuable in overcoming shortages in human resources and skills for the delivery of health services. It was clear from the report that the

mechanism for initiating TCDC in health was poorly understood, poorly coordinated and not well established, resulting in valuable opportunities being lost, and he urged WHO to take an active coordinating role, especially at country level, by providing relevant information and the necessary mechanisms. Experience had shown that collaborative programmes requiring a multi-agency approach might entail problems of authority and responsibility at the country level.

Finally, in view of the vast human resources available in the developing countries, WHO, other agencies and the developing countries were urged to take a new look at financing human resources in relation to TCDC.

Dr KHOGA (Saudi Arabia) suggested reference should be made in the "within countries" section of paragraph 50 of the report to certain services such as continuing education, maternity services and health research; the application of TCDC to them within a region should help ensure appropriate use of resources. In the "within WHO" section of the same paragraph he would like to see reference to concentrating upon the exchange of information among developing countries and the need to convene periodical regional meetings following the World Health Assembly in order to draw up a plan that would be presented to the subsequent Health Assembly.

Dr DLAMINI (Swaziland) said that TCDC had long been recognized as an effective strategy for attaining the target of health for all but that the mechanisms were lacking to implement the concept. She therefore welcomed section V of the report giving ideas which could be used at country level in order to promote technical cooperation among developing countries. WHO should help countries by providing them with the clear guidelines and recommendations that had emerged from the discussions at the interregional consultation held in Jakarta in February 1993.

She noted the action recommended in section VI of the Director-General's report and stressed that countries should incorporate the concept of TCDC in their health development plans; she also requested that WHO Representatives should be equipped to better support countries on TCDC matters.

Finally, in many countries there were various focal points for TCDC in different ministries and she urged that focal points in ministries of health should cooperate with them.

Professor KONDÉ (Guinea) believed that TCDC was an important strategy to strengthen health development in the developing countries and that it should be reinforced by exchanges of experience and study tours, as had been the case when his own country had benefited from the experience of Benin after the launching of the Bamako Initiative for primary health care. Currently, many African and Asian countries were benefiting from Guinea's experience. One of the first countries to benefit from intensified WHO support, Guinea had been able to develop and reinforce manpower skills which, in turn, were assisting neighbouring countries. Such cooperation should be continued and intensified.

Professor MANCIAUX (France) said he fully supported the developments described in the document but was surprised at the lack of emphasis in it on appropriate technology in TCDC in contrast to earlier insistence on that point. He therefore proposed that in paragraph 50 the words "for instance in the field of appropriate technology" should be added after "where expertise from similar countries could be utilized".

Dr DHANVARACHORN (Thailand) said that the key factors in promoting community action for health were sustained political commitment, decentralization, promotion of the leadership role of health care personnel down to the village level, and enhanced community awareness, organization and leadership. In Thailand, technical cooperation among developing countries was being translated into cooperation among developing villages, in a project whereby village health volunteers could observe activities in more developed villages, provinces and countries. The advantages of technical cooperation at the village level were: observation by working volunteers of health problems and solutions in villages similar to theirs; observation of practical solutions; use of a natural form of communication, between villages, at the same level; stimulation of health actions at the lowest level; provision of a budget for action by the Government; and support of the project by WHO, with excellent results. Minor drawbacks of the project were that it consumed a certain proportion of the budget, occupied the time of busy village teachers and sometimes interfered with village budgets.

Dr JARDEL (Assistant Director-General) noted that delegates had requested more detail and different emphases in the text of document A47/4. In particular, they had asked for greater emphasis on means of generating resources to facilitate technical cooperation between developing countries, on the need to organize more forums for exchange of information on such cooperation, and on the fact that it should be integrated into the programming of national health planning. Several alterations had been proposed to paragraph 50 of section VI of the document, including mention of the importance of research in the implementation of technical cooperation, emphasis on appropriate technologies among the fields of knowledge that could be used, and even greater emphasis and greater detail with regard to evaluation of the efficacy of methods for technical cooperation between developing countries. He had also noted that greater emphasis was to be placed on sharing experiences and on cooperation among TCDC focal points at the regional level. The suggestions would be incorporated in the final version of the document.

Dr AZMOUDEH (Islamic Republic of Iran) said that cooperation among neighbouring countries would certainly help them to attain their goals. Information from the regions about the needs of neighbouring countries should be one of the bases of WHO's work in planning technical cooperation.

The CHAIRMAN took it that the Committee wished to take note of the Director-General's report contained in document A47/4 and expressed support for the action suggested in it.

It was so agreed.

2. NINTH GENERAL PROGRAMME OF WORK COVERING A SPECIFIC PERIOD (1996–2001 INCLUSIVE): REVIEW OF DRAFT SUBMITTED BY THE EXECUTIVE BOARD: Item 18 of the Agenda (Document A47/3) (continued)

The CHAIRMAN read out three amendments that had been proposed at the first meeting to the resolution recommended by the Executive Board in EB93.R8 contained in document EB93/1994/REC/1. Finland had proposed on behalf of the Nordic countries that a subparagraph (3) be added to paragraph 4, reading: "to periodically review the implementation of the Ninth General Programme of Work and to adapt it as necessary to take into account emerging issues and the progress made in the reform process in WHO;". The Netherlands had proposed that a new paragraph 5(2) reading: "to establish clear priorities and strengthen the integration of programmes, starting from the programme budget for the financial biennium 1996-1997"; and a new paragraph 5(5) reading: "to strengthen interagency coordination in all relevant programmes involving appropriate agencies in the process".

Dr VIOLAKI-PARASKEVA (Greece) asked for the addition of a preambular paragraph reading: "Aware of the progress made towards the goals and targets of the Eighth General Programme of Work, and recognizing the challenges ahead". If no progress had been noted in the Eighth General Programme, WHO could not continue to the Ninth Programme, as the Executive Board had recognized when it had included that phrase in the preamble to its own resolution.

The draft resolution recommended by the Executive Board in resolution EB93.R8, as amended by Finland, Greece and the Netherlands was approved.

3. IMPLEMENTATION OF RESOLUTIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 19 of the Agenda (resumed)

Health and development (Resolution WHA43.24; Document A47/5)

Professor CALDEIRA DA SILVA (representative of the Executive Board), introducing the report on progress in implementing resolution WHA45.24 on health and development, said that it focused attention on the intolerable health situation of the most vulnerable groups, which constituted a violation of their fundamental right to health, as defined in the Constitution of WHO. Certain economic development policies and strategies had not been adequate to resolve the health problems that confronted such disadvantaged populations; in many cases, they had led to a deterioration in health status, and in some instances they had created new situations of vulnerability. In response to resolution WHA45.24, the Director-General had established a Task Force on Health and Development Policies for the period 1993-1995. A subgroup of the Task Force had met in New York in December 1993 and drawn up a broad framework of questions to be addressed by the full Task Force and a phased strategy of work.

Resolution WHA45.24 called in particular for examination of alternative funding mechanisms that would help countries to evaluate the interaction of health status and economic development policies. That topic would be the focus of an interregional workshop on "banking for health", cosponsored by the World Bank and with the participation of national, regional and international financial institutions, to be held in June 1994. The Executive Board had welcomed the establishment of the Task Force, which comprised eminent personalities in various disciplines and was considered to be well equipped to advocate innovative changes in the area of health and development. The Board had considered that the activities of the Task Force would have a positive effect on technical cooperation.

Health and development also involved consideration of population and basic education. Investment in education and other aspects of human resources had not yet been given the primary focus it deserved; yet, as had been stated at the meeting in New York in December 1993, it was education that would turn a society into a productive one. Development was not a right, it was a value that had to be built and conquered. He invited the Health Assembly to take note of the progress made, although no action was sought at the present time.

Dr AVILA DIAZ (Cuba) said that a report on human development published by UNDP in 1994 had noted a Gini coefficient of 0.87, indicating almost total inequality, as the rich became richer and the poor poorer. That figure hid the real magnitude of the injustice, as it was based on per capita indicators for rich and poor countries and did not take account of the great inequality between rich and poor within countries.

Development presented one of the greatest challenges faced by the world today. The Region of the Americas, for example, had the highest inflation rate, the highest debt burden and the greatest inequality in income distribution. In that economic situation, neoliberal adjustment policies had been applied that had made life even more difficult, especially for the people with the lowest standard of living. Privatization and adjustments in the health sector had affected large sectors of the population, and especially the most vulnerable groups, and had resulted in a worsening of their health situation, something that went counter to the resolution WHA45.24. Current hegemonic tendencies in the political and economic fields had negative consequences on the process of health and disease. People born in the shade of underdevelopment carried that burden to the end of their lives as though it were a genetic defect. It was not the quality of life that was at stake in the developing countries, but life itself.

He was pleased to note the interest in the theme of health and development, but it was important to reduce the disparity between words and action. Insufficient attention was paid to the social and human consequences of the adjustment process, which increased the vulnerability of vulnerable groups. The distribution of wealth during the 1980s had been so unfair that that period had been called the lost decade; equity should be improved so that the decade of the 1990s was not known as the decade of hope forlorn. Human development was a broad, integral concept, but there was a risk that it would become more of a fashion than a practice, more of a catchword than a project for concrete action. Without development there could be no health, and without health there could be no development.

Paragraph 5 of the report referred to a meeting between countries that had focused over the years on improving the health status of the most vulnerable groups. Cuba, which was a developing country, had

not participated in that meeting but had wide experience in the development of health and education systems, with concrete results which could serve in evaluating those themes.

Dr VIOLAKI-PARASKEVA (Greece) said the Health Assembly welcomed the establishment by the Director-General of the Task Force on Health and Development Policies for the period 1993-1995 and hoped that its activities would have a positive effect on technical cooperation. A Global Commission on Women's Health had also been established and she suggested that its work should be mentioned in the report on progress in implementing resolution WHA45.24.

Dr SAVELJEV (Russian Federation) said that although little time had elapsed since adoption of resolution WHA45.24, a certain amount of progress could be seen. He welcomed the establishment of the Task Force and hoped that it would fulfil expectations. The report was correct in identifying the creation of new vulnerable groups as a result of political, social and economic processes in various countries. Such groups were also appearing in republics of the former Union of Soviet Socialist Republics; they included refugees, people who had been forced to move and people who were discriminated against on the basis, for instance, of language. His Government was trying to adopt measures to alleviate the conditions in which those people lived and hoped that international cooperation could provide assistance in this area.

Dr ASHLEY-DEJO (Nigeria) said that, while lip service was paid to establishing an equitable North-South trade balance, there was abundant evidence of imbalance. That imbalance should be addressed if the subject of vulnerability was to be tackled seriously. Developing countries did not set the price of the goods they produced and received a pittance in return for them and they had no say in the price of goods they had to import; that placed them at a perpetual economic disadvantage.

Population growth was an additional problem. The population of Nigeria, already some 90 million strong, was growing at a rate of 3.2% per annum, mopping up social and economic resources. Furthermore, there was constant migration from rural to urban areas, and people living at the periphery of the big cities that had been created were economically disadvantaged and vulnerable owing to the lack of social services. Population growth was thus a major health issue, as health programmes might result in no change in lifestyle or living standards.

He also drew attention to the crucial role of women. They were the centre of family life, so that if women were economically disadvantaged, the rest of the family was in jeopardy. In some parts of Nigeria, women had no right to inherit, they were not allowed to speak at meetings, and they had no access to credit. That situation bred ignorance and poverty, which led to malnutrition and disease and inequalities in health and development. The Task Force set up by the Director-General was to be welcomed, and it should address some of those issues.

Senator GILES (Australia), speaking at the invitation of the CHAIRMAN, as Chairman of the Global Commission on Women's Health, informed the Committee that the Global Commission on Women's Health had been established by the Director-General in 1993 in response to resolution WHA45.25. The Commission was a multidisciplinary, independent body whose remit was to advise WHO and which was responsible for international and national advocacy on policies and measures related to women's health. Its 31 members were drawn from governmental and nongovernmental organizations and relevant bodies of the United Nations system, and they were supported by experts at WHO and other United Nations organizations. The terms of reference of the Commission included preparation of a world plan of action on women's health, urging Member States to collect data separately by gender and advocating the health of women at both governmental and nongovernmental levels. The Commission had met for the first time on 13-15 April 1994 at WHO headquarters, with more than 100 people attending. It had a mandate of three years and would meet at least three times a year, the next meeting being held in Washington, DC in August 1994. The Commission would be closely involved in preparation at global, regional and national levels of the Fourth United Nations Conference on Women. A booklet outlining issues in women's health, entitled "Women's Health: Towards a Better World", had been prepared and had provided guidance for the work of the Commission. It was an excellent handbook and would be distributed widely. Other background material for the first meeting had included reports from interagency, interregional and regional meetings in the European, Eastern Mediterranean and American Regions, a report on selected countries in the

African Region, and reports on activities in women's health in the South-East Asia and Western Pacific Regions. A videotape entitled "Women's Right to Health" had been well received and was available through WHO.

At the heart of the Commission's deliberations was recognition of the right to health and of access, equity, choice and participation in relation to health, without which that right could be neither exercised nor enjoyed. The booklet and videotape illustrated the realities of women's health, from conception throughout life, and examined the effects of global change and trends on the distinct biological and physiological make-up of women. The premature, low-birth-weight daughter of a poorly nourished, adolescent mother, for example, was already one of the world's most vulnerable, disadvantaged people. If she survived infancy and childhood, her life expectancy and quality of life would probably be no better than those of countless women whose lives were ended or made intolerable by frequent child-bearing, poor nutrition or violence or a combination of those and other factors.

Six areas had been chosen as priorities, as they were indicators of the diseases and poor quality of life from which many women suffered. They were nutrition, reproductive health, the health consequences of violence, aging, conditions related to lifestyle, and the work environment. The common characteristic of those issues was that they revealed the effects of inequity, lack of choice and lack of control over life on the health status of women in developed and developing countries. "Health security" did not exist for many women, nor was there any mechanism for accounting for the diminution and waste of life.

In order to address those issues, the Commission had agreed to: form subgroups to deal with policy, advocacy and the normative aspects of women's health; build on and use the technical strengths and existing work on women's health in WHO programmes; use information available in WHO to describe the women's health profiles in different countries; and work with national mechanisms that addressed women's health, and especially national and regional committees, in order to ensure that the subject was addressed thoroughly at the Fourth World Conference on Women. It had been agreed that a phased strategy was essential. Thus, Commission members would first work on selected issues and then build up an agenda as the work of the Commission gathered momentum. The goal of the Commission had the wholehearted support of its multidisciplinary members, the invaluable support of WHO, and the goodwill of many international organizations which had already done much work on women's health. To contribute to improving the health of the world's women within the foreseeable future, the Commission depended heavily on the cooperation and support of the Member States of WHO. Working together, it would be possible to achieve the difference that would mean a better world for women, because that was their right and a precondition for a better world for all.

Dr KHOGA (Saudi Arabia) said that the priorities established under resolution WHA45.24 and listed in paragraph 3(a), (b), (c) and (d) of the document were indeed well-founded and indispensable; however, the paragraph should also include ways of improving capacities in all countries to give health an impact on policies related to various aspects of development. To that end the Organization would need to undertake joint manpower training projects to make national staff aware of experience in health development acquired in other regions. Experience had shown that such WHO manpower training programmes were very useful, but they were not being applied widely enough.

Dr DLAMINI (Swaziland) thanked the Director-General for forming the Task Force on Health and Development Policies in response to resolution WHA25.44, which focused on the unacceptable health situation of vulnerable groups in the world, such as women, children and refugees, and in particular to address the unacceptable situation of the health status of women. She also welcomed the Director-General's response to resolution WHA45.25 by establishing the WHO Global Commission on Women's Health and expressed her appreciation of the report by the Commission's Chairman which the Committee had just heard. The Commission's booklet on women's health should be widely distributed. Despite advances in health development, women continued to be marginalized; their health status was still a disgrace. She hoped that everyone would give the necessary genuine support to improve the health status of the women in the world. The fact that Commonwealth Ministers of Health had chosen women's health as a theme for their meeting next year meant that everyone was being sensitized to the issue.

Ms TIHELI (Lesotho) noted that in many countries the introduction of user fees in an effort to recoup health expenses, owing to economic adjustment, had led to decreased accessibility to health care, especially for the poor who were in most need, and had adversely affected progress in those countries. Alternatives to health subsidies in developing countries such as the Bamako Initiative, in most cases had not led to significant improvement. She therefore welcomed the intention to evaluate and analyse existing policies and strategies to identify better alternatives to protect vulnerable groups.

Unfortunately, in most countries existing traditional institutions had not been identified and used for development and the improved health status of vulnerable groups. In Lesotho, with support from CIIP, traditional institutions such as burial societies and women's groups at village level had started income-generating projects, the profits of which would be used to procure vaccines. Women contributed small amounts of money to pay for delivery fees and care of the mother for the first 10 days after delivery.

She stressed that empowerment, through the change of existing laws discriminating against women, would give that vulnerable group an opportunity to take responsibility for their own health and development.

Dr RIVAS LARRAIN (Chile) said that the complex issue of health and development had at least three important aspects: the relation between the overall development of the country and its effects on the health situation of the population; the significance of the good or bad health of the population to the process of development; and the influence of the health sector on the national economy.

With regard to the first aspect, better economic growth was undeniably a precondition for social development, increased well-being and better health of the population, since more goods and services became available. Nevertheless, the economic process in itself did not guarantee balanced development offering equal opportunities to all, because local development situations differed and because social inequalities might lead to large sections of the population being disregarded or excluded. That situation called for State intervention to regulate and redistribute national wealth. Such social policies played a strategic role in the equitable process of development. Looked at from another angle, public health required regulatory and standard-setting intervention by the State in health activities - a task carried out in accordance with strategic planning in the framework of a national development plan.

Dr SZATMARI (Hungary) welcomed the Director-General's report and stressed that improving a country's health status and reducing the number of vulnerable groups could be achieved only by strengthening self-reliance of peoples and countries. The main road to that goal was education; her delegation therefore underlined the significance of subparagraph 3(d) of document A47/5 giving the terms of reference of the Task Force on Health and Development Policies.

Ms HOLLAND (New Zealand) said that New Zealand's most vulnerable population group with regard to health status was the Maori, and New Zealand suggested that the Task Force should include in its work programme activities relating to the International Decade for Indigenous Peoples.

New Zealand's objective was to increase the health status of the Maori so that they would have the opportunity to enjoy the same level of health as non-Maori. Maori health had been identified as a health-gain priority area for the next three to five years. All health service purchasers would be required to develop and report on strategies to bring about real gains in Maori health status. Three main strategies so far identified were: enhancing the capacity of mainstream services to respond to the Maori; promoting Maori self-sufficiency; and, most important, the socioeconomic advancement of the Maori people.

Current initiatives would be expanded to meet the objectives. In the medium term emphasis would be placed on Maoris taking responsibility for their own health; they would increasingly choose systems and structures that worked for them, and the continued development of Maori health services would see the further establishment of family, community and pan-tribal-based health services. The long-term intention was to develop community-based services to achieve healthy children, women who were respected and held in high regard, and opportunities to care for older people in a way to which Maoris were accustomed.

Dr LAWSON (Benin) said that the problems of women's health had remained hidden for too long. The Global Commission on Women's Health was different from many others in the commitment of its members to action. Priority problems of women's health care had been targeted in the regions and

worldwide. Each member of the Global Commission had made a personal and collective commitment to act effectively at all levels to improve women's health. It had selected a small number of areas in which to concentrate its efforts at first. She herself was committed to gathering more information on the health of girls and women in her country and region and to promote effective and specific actions in all fields to achieve real improvement in women's health. She called upon WHO, other organizations and Member States for support.

Dr MILLER (Barbados) welcomed the formation of the Task Force on Health and Development Policies and agreed with the delegate of Greece on the need to report on the work of the Global Commission on Women's Health. She requested a further report on the implementation of resolution WHA45.24 on health and development (particularly on the work of the Task Force) to the Executive Board and the Forty-eighth World Health Assembly.

Dr HAMMAD (Adviser on Health and Development Policies, Office of the Director-General), replying to comments by delegates, said that many points raised by the delegates of Cuba, Saudi Arabia, Swaziland, Lesotho, Chile, Hungary and New Zealand would be taken into consideration and would provide valuable inputs to the third meeting of the Task Force which would be held in June. As Secretary of the Task Force, she would ensure that the concerns expressed and priority areas outlined by the delegates would figure on the agenda. As the work of the Task Force evolved it was hoped that more information would be made available on the disparities in health status between vulnerable groups and those who enjoyed better health; indicators would be used to measure how much success had been achieved. It was hoped that a more substantive progress report would be made by the Task Force to the next Health Assembly.

The CHAIRMAN took it that the Committee wished to take note of the report in document A47/5.

It was so agreed.

Infant and Young Child Nutrition (progress report; and status of implementation of the International Code of Marketing of Breast-milk Substitutes) (Resolutions WHA33.32 and EB93.R9; Document A47/6)

Professor MBEDE (representative of the Executive Board), introducing the item, said that the Director-General's progress report (document A47/6) was the eighth of a series of biennial reports on infant and young child nutrition, and had been considered at the ninety-third session of the Executive Board. Part I briefly summarized the current global situation regarding malnutrition among under-five-year-old children, in particular protein-energy and micronutrient malnutrition. Part II, on infant and young child feeding, was structured on several themes: encouragement of breast-feeding; promotion of appropriate weaning practices based on the use of local food resources; strengthening of education, training and information on infant and young child feeding; promotion of the health and social status of women; and appropriate marketing and distribution of breast-milk substitutes.

The report reflected the World Declaration on Nutrition and Plan of Action for Nutrition, on which WHO's continuing technical assistance to countries was based. Following the International Conference on Nutrition held in Rome in December 1992, the World Health Assembly in May 1993 had called for the reinforcement of WHO's capacity for food and nutrition action in all relevant programmes. Reinforcement of WHO's capacities included the activities of the inter-programme working group on infant feeding established in 1991 under a global nutrition task force. The Director-General's situation and evaluation report contained, in particular, information on: action taken by WHO Member States, consumer and professional groups and other technical bodies to encourage and support breast-feeding, including the implementation of the WHO/UNICEF Baby-friendly Hospital Initiative and related training activities; monitoring trends in the prevalence and duration of breast-feeding, including the restructuring of the WHO World Data Bank on the basis of new indicators derived from households and from assessing the health facility practices that influenced breast-feeding; exclusive breast-feeding as an infant-feeding ideal and the need for a revised growth reference consistent with the growth patterns of infants fed according to WHO recommendations; food safety issues in infant and young child feeding and the economics of breast-feeding;

and measures taken since 1991 in 50 countries and territories, and in the European Community, giving effect to the International Code of Marketing of Breast-Milk Substitutes.

Some members of the Executive Board had commented in detail on the report now presented as document A47/6, and in particular on the following aspects: the protection of working women, especially by reinforcing the adoption of appropriate legislation so that mothers in paid employment might breast-feed their children; free or low-price supplies of products within the scope of the International Code which should not be available anywhere in the health care system; and the term "breast-milk substitute", which henceforth should replace the expression "infant formula" in WHO texts. Some members of the Board had questioned the advisability of concluding voluntary agreements with the infant-food industry as a means of giving effect to the International Code; others had approved the adoption of such agreements as one of a number of useful measures, depending on circumstances.

The previous version of the Director-General's report had been modified to take account of comments by Board members. Additional information had been supplied on the way Member States were giving effect to the Code in the light of national circumstances by the adoption of legislation and regulations or by other suitable means. Similarly, information originally supplied to the Forty-third World Health Assembly in 1990 on the samples and supplies of products within the scope of the Code appeared in the current report. In its resolution EB93.R9, the Executive Board had recommended to the Health Assembly the adoption of a resolution on infant and young child nutrition, as mentioned in paragraph 165 of document A47/6. In that connection the Board had felt there was a need to emphasize three points: ensuring that no free or low-price supplies of products within the scope of the Code were made available in any part of the health care system; linking the provision of free or low-price supplies of products within the scope of the Code to emergencies; and using the term "breast-milk substitutes" instead of "infant formula". The views of the Health Assembly on those matters would be appreciated.

Dr CICOGNA (Italy), thanking the Director-General for his report, observed that paragraph 2(2) of the resolution proposed in resolution EB93.R9 needed to be brought into line with Article 6.6 of the International Code of Marketing of Breast-milk Substitutes, and therefore proposed adding to that paragraph after the words "health care system", the words: "other than as stipulated in Articles 6.6 and 6.7 of the International Code, and as clarified by the relevant WHO guidelines and by resolutions WHA39.28 and WHA45.34".

Noting that paragraph 2(3) of the same resolution implied that donations were only permitted in the context of emergency relief operations, which was not stated in Articles 6.6 and 6.7 of the International Code, he proposed to bring the resolution into line with the Code by splitting the text of the paragraph into two. Paragraph 2(3) would read: "to exercise extreme caution when planning, implementing or supporting emergency relief operations by protecting, promoting and supporting breast-feeding for infants", and a new paragraph 2(4) would read: "to ensure that donations of free or subsidized supplies of infant formula or other products within the scope of the International Code outside the health care system be provided as stipulated in Article 6.7 of the International Code and only if all the following conditions apply:", followed by (a), (b) and (c) as they currently appeared under paragraph 2(3).

Lastly, in his view paragraph 2(1)(d) did not adequately reflect the terms of the International Conference on Nutrition World Declaration and Plan of Action, and should be amended to read: "promoting sound weaning practices by encouraging the use of nutritionally adequate, safe and appropriate locally available foods after the first four to six months, while emphasizing the importance of continued breast-feeding".

Dr WANG Yifei (China) said that since its adoption in 1992, the World Declaration on Nutrition had become the guideline document governing WHO's support to Member States. Satisfying the nutritional requirements of women and children had become a central element in the WHO programme. During recent years, great progress had been made in China, where the concept of safe motherhood and breast-feeding had been popularized. The Ministry of Public Health was preparing a directive, requiring that health institutions should reject any offers of free or low-priced breast-milk substitutes. It was hoped that deficiency disorders would be eliminated by the year 2000.

He proposed that WHO should improve the coordination of all its programmes on nutrition, and should do further work on diarrhoea control. Guidance on breast-feeding - which was closely linked with

customs in different countries - should be provided in accordance with the needs of low-income and disaster-stricken areas. WHO should also provide technical and financial support to Member States in formulating and implementing national action programmes, and should appeal to other United Nations agencies to live up to their commitment to nutrition.

Mr ORTENDAHL (Sweden) said that his country strongly supported the banning of the advertising of breast-milk substitutes in order to make clear the dangers to children's health of well-meant donations of large quantities of those products to eastern European countries. Many of the new market economies in Africa and Asia also required immediate assistance from WHO to protect breast-feeding.

The International Code covered a wider area than "infant formula", and it was unfortunate that WHO statements sometimes referred to the latter, where it would be more appropriate to speak of "breast-milk substitutes". Sweden encouraged WHO to join with other relevant bodies of the United Nations system in drawing up guidelines to prevent such substitutes being indiscriminately distributed to countries not yet aware of the dangers involved.

His delegation strongly supported the resolution proposed in resolution EB93.R9. Sweden felt that it was only by using such forthright language that it would be possible to terminate the unethical practice of allowing free supplies to subvert the role of the health care services in protecting, supporting and promoting breast-feeding. The distribution of free supplies should be banned from all health facilities.

Infant and young child nutrition was an important area for normative action on the part of WHO; it constituted a testing-ground for WHO's role. Further steps had to be taken to secure adherence to the International Code. It might be possible to agree on a no-change policy in relation to the Code, if it were certain that implementation and monitoring measures would live up to expectations; the proposed resolution provided a good basis for that. However, the proposal of the Italian delegation was not acceptable to Sweden.

Professor MANCIAUX (France) stressed the importance of the issue under consideration and the need to pay close attention to drafting on that subject. France supported the principles enunciated by WHO to encourage breast-feeding. They needed to be repeated from time to time. Improved training and education were required in that connection, as well as promotion of the health and social status of women. There should be appropriate marketing and distribution of breast-milk substitutes. Stress should also be laid on the training of health workers, which was improving, but too slowly.

The recommendations of the International Code had been taken up in a European directive, which was currently being incorporated into the legislation of the European Union's Member States. Any changes by the Health Assembly to the International Code would put in jeopardy the steps taken by the European Union: a global policy was accordingly essential in that area.

In connection with the fourth preambular paragraph of the resolution proposed by the Executive Board in resolution EB93.R9, he felt it was inappropriate to speak of breast milk as a "biological norm" for nourishing infants, given the variability of that norm. He proposed that the French text of that paragraph be reworded as follows:

"Considérant la superiorité du lait maternel pour l'alimentation du nourrisson et compte tenu du fait que toute autre pratique peut accroître les risques pour la santé du nourrisson et de la mère;"

With reference to paragraph 2(1)(d), he felt that it was inappropriate to fix an age "of about six months" for complementary feeding practices, whereas the Code spoke of a period of four to six months. He therefore suggested the wording: "after the first four to six months of life", which would leave room for manoeuvre in view of varying customs in different parts of the world.

The French delegation endorsed the proposals made by the delegate of Italy; it also favoured continuing the periodic assessments of the implementation of the Code on a biennial basis.

Professor ORDOÑEZ CANCELLER (Cuba) supported the report on infant and young child nutrition.

Since the national programme of action had been set up in 1990, Cuba had guaranteed proper nutrition for mothers and children, and a national strategy had concentrated on promoting breast-feeding. A national goal of having 95.3% of live births breast-fed had been adopted in 1993 and "sentinel centres" had been set up to monitor food and nutrition. He outlined the national goals to increase breast-feeding,

which began immediately after birth, with a rooming-in and bonding policy. Baby-friendly hospital initiatives were being successfully implemented and had been positively assessed by UNICEF experts. Training courses were being provided by the Federation of Cuban Women, as well as by the Ministry of Health. Milk substitutes were only provided for infants which could not be breast-fed, and they were subject to strict supervision.

Ms MILLS (Canada) said that her delegation was pleased to note that progress was being made with regard to infant nutrition, and that collaborative and comprehensive action had culminated in positive results. It commended WHO's continuing efforts to tackle specific nutritional deficiencies, as well as to improve the health of mothers and their social environment. Canada supported the resolution put forward by the Executive Board.

Ms LAURIDSEN (Denmark) said that her country had supported the resolution from the outset. However, it would be appropriate to study the amendments proposed by Italy and France more closely, she accordingly favoured the establishment of a drafting group on the resolution.

To avoid any misunderstanding in connection with the remarks made by the French delegate, she pointed out that it would not be necessary to make any changes to European Community law, which was already in line with the code of WHO.

The CHAIRMAN said the suggestion to set up a working group would be considered later.

Dr VIOLAKI-PARASKEVA (Greece) said that her delegation supported the report in document A47/6. She was astonished that after 12 years' debate on breast-milk substitutes, the discussion was still continuing. There were some points in the document which needed to be clarified, such as the exact number of children who were HIV-infected as a result of breast-feeding.

She suggested that the draft resolution should be discussed during the afternoon meeting, in line with the proposals made by the Danish delegate, with a view to reaching a consensus.

Dr LOUME (Senegal) added, further to the information in document A47/6, that in 1993, his country had set up a multidisciplinary, multisectoral working party to give effect to the national policy of encouraging breast-feeding. A national workshop was shortly to be held, followed by a national forum to bring the campaign to the attention of the public, religious and traditional authorities. Training activities for health professionals from professors to community health workers would commence in June.

His government supported the resolution proposed by the Executive Board. However, he did not agree with the amendment proposed by Italy. It was important that the wording should be very clear, so as to avoid leaving room for possible abuse.

Dr TIERNEY (Ireland) welcomed the report and supported the initiative to promote breast-feeding, which constituted official government policy in Ireland. His delegation endorsed the proposals made by the representatives of France and Italy, which would bring the document into line with the International Code and with the Plan of Action for Nutrition.

The meeting rose at 12h30.

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