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PROVISIONAL SUMMARY RECORD OF THE FOURTH MEETING

Palais des Nations, Geneva
Thursday, 8 May 1997, at 9:10

Chairman: Professor H. ACHOUR (Tunisia)

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FOURTH MEETING

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GENERAL REVIEW: Item 17.1 of the Agenda (Resolutions EB99.R13 and EB99.R14; Documents PB/98-99, A50/4, and EB99/INF.DOC./1) (continued)

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Programme 4.3 (Nutrition, food security and safety)
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Dr AL-SAIF (representative of the Executive Board) said that the Executive Board had reaffirmed the priority of nutrition and food security and safety issues, considering the budget cuts in the area regrettable. The Board had reiterated the importance of WHO's role in the setting of standards for food safety and nutrition and its continued support for international food safety regulations. It had also received confirmation that WHO was honouring its contractual commitments to the Codex Alimentarius Commission. The Executive Board had also considered the need for WHO to establish guidelines on the provision of food aid, taking into account the informal guidelines that already existed.

The Executive Board reaffirmed its satisfaction with the proposed allocation for environmental health, another priority area. There was growing awareness of the links between health and the environment and every effort must be made to ensure that WHO continued to provide leadership in the area, particularly in the setting of vital norms and standards at the global level. WHO's promotion of chemical safety, the identification of chemical carcinogens by IARC, WHO's follow-up to Agenda 21 of the United Nations Conference on Environment and Development and the work performed by the Intergovernmental Forum on Chemical Safety were cited as examples of crucial international work on environmental health.

The Executive Board had considered that in developing countries facing a multitude of environmental problems, the provision of sanitation and a safe and adequate water supply remained a top priority requiring leadership from the health sector and collaboration with other sectors. WHO should also consider the health consequences of industrial development. In that context, the Board was given an assurance that the closely related activities of specific programmes 4.4.2 (Environmental health in urban development) and 4.4.4 (Promotion of chemical safety) were being coordinated so as to avoid duplication and ensure cost-effectiveness at the operational level.

Several members of the Board had referred to the national environmental health action plans recently developed in various regions as a good example of how much could be achieved with minimum resource investment. The plans involved devising national policies in line with health-for-all policies and relied on intersectoral and interministerial collaboration. They had proved highly successful in achieving their goal and attracting extrabudgetary funding. Although the Board had questioned the general desirability of increased dependence on extrabudgetary funding, the plans were thought to demonstrate how donors could be attracted simply by the quality of the Organization's work. Initiatives such as those for healthy cities and healthy villages were also cited as examples of WHO's effectiveness in promoting environmental health.

Dr VAN ETTEN (Netherlands) said specific programmes 4.3.1 (Nutrition) and 4.3.2 (Food safety) were priorities for his country and he favoured maintaining their appropriations at the same level as in the current biennium, particularly in view of the discontinuation, which he supported, of specific programme 4.3.3 (Food

aid). He requested clarification of the substantial increase in specific programme 4.4.2 (Environmental health in urban development) at the apparent expense of specific programme 4.4.1 (Water supply and sanitation in human settlements).

Dr AGARWAL (India) gave a brief survey of recent action initiated by his Government in the area of environmental health and described some of the measures planned under the Ninth Five-Year Plan launched on 1 April 1997. The Supreme Court of India had directed the installation of incinerators and other hospital-based disposal mechanisms in all government and private sector hospitals of more than 50 beds. On a pilot basis, a programme had been launched in collaboration with WHO to turn Delhi into a healthy city. Environmental health and sanitation played an important role in the negotiations between the Government of India and the World Bank and other external donor agencies.

Ms NGHATANGA (Namibia) reported that her country had devised a Food and Nutrition Plan of Action in 1996, thanks to the support of WHO and FAO. Nevertheless severe drought over the previous five years had caused food insecurity to persist at the household level. Although the rains had been good in the current year, drought was likely to remain a problem. She described the health and other problems experienced by many families as a result of the unavailability of food, which were compounded by extreme poverty and social hardship. Improving food and nutrition remained a priority for many drought-stricken, food-deficit countries like her own, and external assistance was essential. Expressing her appreciation for the support received, she appealed to WHO, through agencies such as FAO and the WFP, to provide assistance through community-based health and development programmes to enable the poor to engage in activities that would improve their economic, and hence their food and nutritional, status.

Professor AKIN (Turkey) thought the problems relating to nutrition and food were well stated under programme 4.3 in document PB/98-99, but she wished to draw special attention to three major problems, all of them preventable. The first was malnutrition in children, which contributed substantially to childhood diseases and death but often went unrecognized; almost one third of the world's children under five years of age were underweight. Secondly, micronutrient malnutrition affected at least 2 billion people of all ages, with children particularly vulnerable; iodine and vitamin A deficiency continued to be a serious public health problem. The third problem was anaemia in pregnant women, and it was well known that anaemia was the leading underlying cause of maternal deaths in many countries.

She commended WHO on the many intervention strategies it had developed at the global, regional and country levels. She would comment briefly on a few. While the promotion of breast-feeding management and the development of criteria for implementing baby-friendly hospital initiatives were progressing well in many countries, including her own, she called on WHO to make the programme more comprehensive by establishing criteria for "mother- and baby-friendly" health units, or even communities. Without a healthy mother it was hard to produce a healthy baby. The magnitude of the problem of anaemia in pregnancy was such that research was urgently required to establish the most cost-effective type of intervention and assist countries in introducing the most appropriate technology. User compliance being a major problem, new technologies should be developed to minimize or eliminate the problems. The development by WHO of new global growth reference values for infants and children was both welcome and timely, and would be of widespread value. With regard to iodine deficiency, she called on WHO to provide advocacy activities, in addition to technical support, in order to publicize the issue better and help in convincing policy-makers and the public to generalize interventions.

Dr KORTE (Germany) welcomed the excellent progress of the programmes under review, for which support and budgets should be maintained at least at previous levels. He thanked the Director-General for his initiative on urban health, an area to which the speaker attached particular importance and which would determine the well-being of many millions of people. With the liberalization of trade, food safety would grow in importance. WHO should continue to exercise its leadership in the field and draw up recommendations and standards to prevent health problems related to unsafe food. He welcomed the timely

initiative to set new growth standards, which would form a new reference framework for measuring over- and undernutrition.

Dr SANOU IRA (Burkina Faso) said that problems of nutrition, food security and safety were a cause of growing disquiet in the developing countries. Malnutrition was compounded by other problems connected with imported foods, and the safety of both agricultural and processed products left much to be desired. However, it was difficult to get the message across to the people. Given that poverty was the largest determining factor, it was difficult to know where to start tackling the problems. At the global level, there was collaboration between WHO and other international bodies, and she paid tribute to WHO's work in the field. WHO's support in setting up an effective system of hygiene management in general and food safety in particular was a matter of real priority in her country. She, too, regretted the budget cuts and urged that every effort be made at local level, with the support of the regional offices, to ensure that the programmes already launched in her country and others were truly strengthened.

Dr ABEDNEGO (Indonesia) described some of the measures being implemented in his country in the areas under consideration, in particular those benefiting schoolchildren and addressing environment quality, micronutrient deficiency, school health and poverty alleviation.

Professor GRINGAUD (Algeria) was concerned at the budgetary restrictions on nutrition programmes in view of the lack of progress in overcoming protein-energy malnutrition and the seriousness of micronutrient deficiencies highlighted in the documentation. It was important to mobilize new resources through an intersectoral approach designed to link food production, community development and food supplementation for the populations at risk. Algeria planned to launch such a project in the southern part of the country and to enlist the cooperation of various international agencies. He warmly endorsed the remarks of the delegate of Burkina Faso regarding food safety.

Dr AL-JABER (Qatar) said there was no doubt that environmental health and nutrition were of paramount importance to general health, that many diseases stemmed from lack of environmental health, that production of chemicals had a direct impact on human health and that additives had adversely affected human health. After outlining some of the action being taken in his country to tackle the problems, he urged WHO to continue its support to programmes related to environmental health and nutrition.

Mrs HERZOG (Israel), observing that the issues under review were interrelated, said that the efforts made, within the budgetary constraints, were to be commended. Nutrition and food security and safety were matters of universal concern. While the WHO guidelines for travellers were most useful, food hygiene and safety was not only a concern of travellers, as increasing numbers of people ate outside the home. Alongside WHO's commendable achievements on surveillance and evaluation at the global, regional and country level, guidelines should continually be sent to Member States on hygiene in all aspects of food processing and sale.

The quality of food in health terms was another important issue in the industrial and developing countries. Prepared food contained too much salt, saturated fat and sugar. Here, too, WHO could act as a catalyst in providing guidelines to Member States, lay people and nongovernmental organizations. Education at all levels was clearly an important factor in bringing about changes in practice and behaviour and, here too, WHO should use other existing frameworks such as health-promoting schools and healthy cities.

Professor LEOWSKI (Poland), speaking on major programme 4.4, noted that environmental protection had been intensified in the five years since the United Nations Conference on Environment and Development (UNCED), greater emphasis being put on environmental health risks in WHO as elsewhere. He welcomed the fact that the scope of the joint WHO/UNDP initiative to support countries' sustainable development planning had expanded from 6 to 16 countries between 1993 and 1996. Subject to further developments and according to the criteria decided for country selection, Poland might be interested in cooperating on the project.

All Member States were interested in international cooperation on environmental health action plans, as emerged from the two conferences organized by the Regional Office for Europe in the wake of the Second European Conference on Environment and Health (Helsinki, 1994), and Poland would welcome implementation of the bilateral agreement signed with that office for the current biennium. The report of the WHO Commission on Health and Environment, entitled *Our planet, our health*, presented to UNCED had been crucial to the high priority assigned to health in the context of sustainable development. He also supported the idea of producing a report on health and environment in sustainable development that would revise the situation five years after UNCED. In his view, the report should demonstrate the links between environment and health and analyse the impact that implementation of sustainable development policies had had on environment and health. Since Poland had shown positive results in those areas, it would be willing to cooperate with the high-level panel recommended by the Director-General's Council on the Earth Summit Action Programme for Health and Environment.

In view of the growing amounts of chemicals and the dangers they posed, he indicated the need for further intensive efforts for promoting chemical safety.

Professor QURAISHY (Pakistan) expressed appreciation for the continued support for food safety, community health and the environment. With regard to major programme 4.4, Pakistan had made great strides over the past two years in dealing with environmental hazards and had passed legislation to tackle industrial and hospital waste, including the requirement that all hospitals with over 50 beds in large cities use incinerators, which would be fully met by the end of 1998. Industrial safety and control of chemical waste was also on the agenda.

Under major programme 4.3, he regretted the decline in WHO support for nutrition programmes; nutrition and food safety still required much support in most developing countries. To control malnutrition and ensure the health of its future adult population, Pakistan was strengthening its school health service and improving its activities for the nutrition of mothers and children.

Dr SULAIMAN (Oman) remarked that appropriate resources were needed for implementing nutrition and environmental health programmes and for the attainment of long- and short-term goals. Given the growth of the food industry and the increased use of chemical additives and their consequences, he wondered how much of the programme resources would be earmarked for dealing with iodine and other deficiencies and for human awareness programmes. He welcomed the field studies and programmes on mother-and-child nutrition, which should help reflect the true status of nutrition, particularly in early childhood.

Dr DLAMINI (Swaziland) thanked the Director-General for the programmes proposed, but felt that stronger collaboration was needed in certain areas.

Referring to major programme 4.3, she expressed concern at the continued budgetary constraints on nutrition for Africa. The severe droughts that had hit her country in recent years were still contributing to malnutrition. There had also been significant pathology from deficiencies of micronutrients. The Swaziland Nutritional Council was being revived and required considerable funding. Food contamination by insecticides and the use of chemicals and food additives was another area of major concern, which called for research into food additives and their effect on human consumers. Swaziland had passed legislation that required all salt to be iodized. She therefore urged WHO to continue its funding for all those areas, despite the reduced budget.

On major programme 4.4, she called for WHO's cooperation to combat water contaminants; countries sometimes lost sight of the need for river safety in their attempts to entice investors, thus encouraging dumping of industrial waste into rivers. When preventive legislation did exist, it was not necessarily enforced.

Dr OTTO (Palau) was grateful for the presentation on nutrition, food security and food safety in the proposed programme budget, especially the proposed products and projections on nutrition. Since the prevalence of obesity in adults was over 50% in the Western Pacific countries, half those countries' population ran the serious risk of a progressively reduced quality of life; consequently, he welcomed the

proposed actions, particularly the development of methodology to monitor, prevent and reduce obesity and the global database and monitoring system. He looked forward to receipt of the proposed guidelines on public health policy on obesity.

Ms VOGEL (United States of America) noted that the budget proposed for specific programme 4.4.1 (Water supply and sanitation in human settlements) was substantially less than that for the current biennium, but that the document did not indicate what activities would be suppressed in consequence. Although UNICEF, UNDP, UNEP and the World Bank were all involved in the overall process to ensure safe water and adequate sanitation, WHO still had an important role to play.

Dr BROOKMAN-AMISSAH (Ghana) observed that the excellent programmes presented accurately reflected the problems faced by most African countries. With respect to major programme 4.4, many countries, especially in the developing world, were plagued by poor environmental management capabilities, particularly for waste disposal, which called for expensive and complex state-of-the-art technology and massive engineering inputs; they lacked both the financial resources and the specialized personnel. Those countries could benefit from a return to older, simple technologies suited to small rural and larger urban communities for disposing of solid and liquid waste.

Dr BOUANGA (Congo), referring to major programme 4.3, called on the Organization to redouble its efforts to secure funding for concrete action to establish appropriate mechanisms for promoting chemical safety, especially in the countries most severely beset by environmental problems. He thanked the Organization for increasing the appropriations from the 1996-1997 levels and hoped that projects with multiplier effects would be implemented in the area of food safety and security. Malnutrition was a major cause of disease and mortality among Africans; accordingly, WHO must continue to play its leadership role to ensure that the goal of health for all by the year 2000 was attained jointly and equitably.

Dr PRADO (Nicaragua) suggested that the budget for major programme 4.3 be maintained at the previous level. Micronutrient deficiencies in Nicaragua posed a serious threat to nursing mothers, babies, and pregnant women and were causing a rise in neonatal and maternal disease and death rates. Accordingly, his country was expanding a number of health programmes to include health of nursing mothers and mother-and-child nutrition. However, it needed help in order to attain its goals.

Mrs PAULINO (Philippines) supported WHO's initiatives for proper and adequate nutrition and food security and safety. Inasmuch as adequate nutrition reduced vulnerability to ill-health and was therefore crucial to children's overall development and future productivity, she was concerned about the instability of the budgetary support for nutrition and related issues and, hence, the level of activities. She therefore urged the Organization to take the lead in undertaking further studies to identify simple and sustainable community-level strategies for ensuring safe and adequate food for families.

Mrs NINH THI BINH (Viet Nam) welcomed the excellent presentation of the programme on nutrition and food security and safety, both of which were very serious issues in the developing countries. Viet Nam would support an increase in appropriations for that area, since it had a malnutrition rate of 42% among children under five years and had undertaken to cut that to 32% by 2000.

Dr MTSHALI (South Africa) expressed appreciation for WHO's work on nutrition and called for further support for countries in need. South Africa suffered from the myriad health consequences of poor nutrition, especially protein and micronutrient deficiencies, and was therefore evaluating various food-fortification activities and contemplating multisectoral action to ensure household food security. One major area of concern, in which WHO could be of assistance, was salt iodization; while many countries required salt consumed domestically to be iodized, control measures for exported salt were often neglected, allowing non-iodized salt to be dumped on salt-importing countries. A further possible problem was that of the Organization's cooperation with other United Nations agencies. A case in point was the fact that South

Africa's Health Directorate dealt primarily with UNICEF on many of the activities covered in WHO's major programme 4.3; she wished to ensure that there was no conflict of interest or duplication of work.

Mrs MANYENENG (Botswana) said that there should be continued support for major programme 4.3. The upsurge of food vending and institutional feeding had increased the importance of food quality and pointed out the urgency of establishing food standards and legislation and of educating food consumers and producers alike. In view of the small amounts earmarked for nutrition and related areas, she hoped that the importance of the link between malnutrition and opportunistic diseases would not be neglected.

She welcomed the prominence accorded environmental health under major programme 4.4. Given the seriousness of the problem of chemical safety and the disposal of hazardous waste, she urged WHO and FAO to continue to provide support.

Dr MISHKAS (Saudi Arabia) expressed his wholehearted agreement with major programme 4.3, particularly regarding the important contribution made by certain nutrient deficiencies to diseases that were widespread both in the industrialized and developing countries. Breast-feeding had been given considerable attention in Saudi Arabia, since it had been shown to stave off breast cancer in nursing mothers.

Professor PICO (Argentina) agreed with the contents of major programme 4.3 and thanked the Organization for its achievements in nutrition and food security and safety, and more particularly for its assistance with the development of Argentina's National Food, Medicine and Medical Technology Administration which made it possible to monitor the nutritional status of the population. Argentina had a fully operational national nutrition programme which emphasized many of the same features as those covered in the programme budget. It was also important for all programmes relating to breast-feeding to be vigorously pursued.

Dr SIKOSANA (Zimbabwe) congratulated the Organization on its achievements in nutrition and environmental health and joined other delegates in calling for increased funding for those programmes. The work of WHO had resulted in an improvement in the nutritional status of the population of Zimbabwe and particularly of children under the age of five, despite devastating droughts in the region. In order to sustain those achievements, a food and nutrition policy was being developed. The HIV/AIDS epidemic, however, had negatively affected policies for breast-feeding and the "baby-friendly hospital" initiative.

Although legislation had been enacted to ensure universal iodization of salt, an increase in the prevalence of thyrotoxicosis had been seen. Technical assistance would be required to monitor that serious side-effect of the programme.

Programme 4.4 (Environmental health) had allowed Zimbabwe to highlight environmental problems in both urban and rural areas; the "healthy cities" initiative was to be followed by a "healthy villages" initiative, based on competitions among villages.

Mr ROKOVADA (Fiji) said that a plan of action was being implemented in his country to address malnutrition, micronutrient deficiency and obesity, which were significant risk factors for a range of noncommunicable diseases, and to cover food security and safety. Breast-feeding was promoted as part of the "baby-friendly hospital" concept; the two major hospitals of the country and one divisional hospital had been given that accreditation. A national health promotion centre had been established in 1996 with the assistance of the Governments of Australia and Japan. The centre collaborated with other agencies in developing health strategies, such as "health-promoting schools", "healthy islands" (as a corollary to "healthy cities") and building healthy work-sites in industry.

Dr SILWAMBA (Zambia) expressed gratitude for the guidance given on nutrition, on food security and safety; that was tempered, however, by concern for the apparent lack of support in the area of environmental health. Little was said, for example, about assisting developing countries to detect and dispose of radioactive material. Some years previously, a consignment of tinned beef had been sent to his country from Europe which had subsequently been found to be radionuclide contaminated. As the proper mechanisms for disposal

of the product had not been available, it had been placed in a concrete-lined pit, to which people had nevertheless gained access. Similar cases of the dumping of rejected material on developing countries had been reported elsewhere.

Dr HAJAR (Yemen) noted that environmental health, nutrition, food security and safety and water supplies were areas of fundamental importance. Iron- and iodine-deficiencies were major problems in his country, where an inventory of the situation was being prepared with the assistance of the Regional Office, in collaboration with hospitals and other health services. He considered that the appropriations for environmental health should be increased in view of the cardinal importance of good water supplies and sanitation.

Dr KHARABSHEH (Jordan) said that his country attached paramount importance to the environment as a means of health promotion. Countries that lacked drinking-water required assistance, not only from WHO but also from other international bodies, in finding adequate supplies. An equitable distribution of drinking-water among neighbouring countries had to be assured.

The promotion of chemical safety (specific programme 4.4.4), represented a problem in many countries. It should be kept under constant review by WHO, in cooperation with all the other relevant bodies, in order to ensure the safety of all chemicals whether produced in civilian or defence establishments.

Turning to national food programmes, he stressed the importance of continuing to monitor food security and safety, both for the control of outbreaks of foodborne disease and for the prevention of endemic diseases. Countries which were not yet doing so should introduce monitoring plans in accordance with the appropriate standards.

Mr YOUSEF (Kuwait) noted that the concept of nutrition was a broad one that included many things, including possible contaminants, additives and preservatives in food products, which might themselves be directly or indirectly hazardous to health. Like many countries, Kuwait imported most of its food products and wished to ensure their safety. WHO should increase the allocations for laboratory analysis and control of food production and provide for training in that respect.

Dr ANTEZANA (Deputy Director-General *ad interim*), responding to questions about programme 4.3 (Nutrition, food security and safety), recalled that the Director-General had decided to further strengthen the effectiveness, visibility and operational nature of the programme by including nutrition in all of the specific programmes within major programme 4.1 (Reproductive, family and community health and population issues). A specific programme on food safety and security was required in view of recent concern with regard, for instance, to Creutzfeld-Jacob disease, problems associated with Escherichia coli and Salmonella and chemical contamination of food. Unhealthy diets were becoming a daily problem because of changing lifestyles and intensified travel. The activities of the food safety programme had been increased, despite budgetary restrictions; owing to the cooperation of the Government of Japan, WHO was actively participating in the Codex Alimentarius Commission and in negotiations with the World Trade Organization.

Dr KÄFERSTEIN (Food Safety and Food Aid), referring to comments from delegates about a possible lack of intersectoral collaboration for food security and safety at the country level, said that national committees and national contact points of the Codex Alimentarius Commission should be established in countries; they could ensure such cooperation. In collaboration with UNIDO, a programme was being launched to strengthen the food industry in seven African countries, that programme would involve ministries of health. Another mechanism for improving intersectoral collaboration was the "healthy-city" initiative and the newly devised "healthy market place" initiative.

Regarding the need for more information on food preparation, he noted that WHO had already issued hygiene rules for mass catering, and "golden rules" for safe food preparation in the family had been published 10 years previously. A recent WHO publication had addressed essential safety requirements for food sold by street vendors.

Dr TURMEN (Family and Reproductive Health), responding to comments on specific programme 4.3.1 (Nutrition), said that nutrition was an essential element for the health and well-being of people throughout their lives. Inclusion of work on nutrition in all aspects of family and reproductive health would strengthen its impact. Nutrition was a priority for WHO, as malnutrition killed, maimed, crippled and blinded people throughout the world: 197 million children under the age of five suffered from protein-energy malnutrition, 750 million people had iodine-deficiency disorders, 2.8 million children under five were blind owing to vitamin A deficiency, 1200 million people suffered from iron-deficiency anaemia and several hundred million children, adolescents and adults were obese.

She thanked the delegate of the Netherlands for the long-lasting support of his government in fighting malnutrition, both through WHO and directly with countries. Many delegates had cited the global problem represented by protein-energy malnutrition, iodine deficiency, vitamin A deficiency and anaemia, especially in pregnant women. WHO continued to support Member States both technically and financially in pursuing the goals of the 1992 World Declaration and Plan of Action for Nutrition. The incidence of iodine-deficiency disorders was decreasing throughout the world owing to the introduction of iodized salt, and they might actually be eliminated by the year 2000; a report would be made to the World Health Assembly in 1999.

With reference to the delegate of Zimbabwe's remarks on iodine-induced thyrotoxicosis, she recalled that a warning on the subject from Zimbabwe two years previously had prompted WHO, UNICEF and the International Council for Control of Iodine Deficiency Disorders to carry out an epidemiological study in several African countries, which had led to strengthened monitoring of iodized salt programmes throughout the world.

A database on body mass index was being established which would serve as a framework for defining and measuring under- and overnutrition, a point that had been raised by the delegates of Germany and Palau. An international meeting on obesity was to be held in June 1997. Monitoring of the growth of individuals and assessment of the extent of malnutrition at country and global levels were actively supported by WHO, mainly within the specific programme on nutrition and the Division of Child Health and Development. WHO was conducting a large international study on which to base a new international growth reference value for children under five, and was providing support to more than 140 Member States so that they could strengthen growth-monitoring activities.

In response to a comment by the delegate of South Africa, she said that many of WHO's activities in nutrition and national nutrition programmes were conducted jointly with UNICEF and FAO. The activities were coordinated annually at meetings with UNICEF and with all of the United Nations agencies concerned with nutrition, so that the scarce resources were not used to duplicate activities.

Replying to the delegate of Turkey, she said that WHO considered that any initiative that was "mother-friendly" would naturally be "baby-friendly" and was preparing criteria and guidelines to move from the concept of "baby-friendly hospitals" to "mother- and baby-friendly hospitals".

With regard to the complex issue of HIV and infant feeding, raised by the delegate of Zimbabwe, she recalled that WHO had long emphasized the vital importance of promoting, protecting and supporting breast-feeding for the survival and health of infants throughout the world. The growing HIV/AIDS pandemic and evidence that HIV could be transmitted in human milk had, however, led WHO periodically to review its policies in that respect. The most recent statement had been issued in conjunction with UNAIDS in September 1996. It described considerations for countries that were setting policy on the issue and for health-care workers who advised women about infant feeding.

An international study was under way with the aim of improving the security of household food and nutrition for vulnerable groups, particularly in cities. Socioeconomic, cultural and environmental factors and the caring capacity of populations were being studied in order to develop guiding principles to be incorporated in national food and nutrition policies and plans.

Dr KREISEL (Environmental Health) said that the delegates' comments on programme 4.4 (Environmental health), indicated growing global concern about the implications for human health of a deteriorating environment; he reminded the Committee that 25% of all preventable disease was due to poor environmental quality.

The delegates of the Netherlands and the United States of America had asked about the potential effects of the proposed US$ 12 million decrease in the budget for specific programme 4.4.1 (Water supply and sanitation in human settlements) and the proposed increase in the allocation for specific programme 4.4.2 (Environmental health in urban development). The two programmes had similar allocations at headquarters, as in the previous biennium, but a shift was being proposed at the regional level owing to the success of the "healthy cities" ("healthy villages", "healthy islands" and "healthy communities") initiative within programme 4.4.2. That sort of integrated approach to environmental health management was finding increasing favour at the country level, in preference to specific support for single activities. An interregional programme for healthy cities had been established, in which cross-programme working groups ensured cross-fertilization of ideas. The "healthy market places" initiative that had been mentioned by Dr Käferstein in the context of food safety was a good example of that approach. The allocation for specific programme 4.4.1 would be reduced also because fewer staff worked specifically on water supplies and sanitation; countries requested broader expertise in environmental health. The approach used by WHO to address the problem of water supplies and sanitation was education in hygiene, operation and maintenance of water supply and sanitation systems and monitoring of drinking-water quality. The necessary hardware was provided by organizations like the World Bank, which had the appropriate investment programmes. WHO was strongly involved in interagency collaboration in that area, for instance providing the secretariat for the Global Collaborative Council on Water Supply and Sanitation. It was also fully involved in developing a global programme on water, supported by the Commission on Sustainable Development of the United Nations. WHO would supply the focus on health in relation to supplies of fresh water.

In response to the delegate of Poland, he said that more than 100 countries had incorporated health and environment components into their plans for sustainable development. Examples were the national environment and health action plans in Europe and similar initiatives in other regions. Such plans emphasized intersectoral action, which was essential in order to achieve the goal of environmental health. The report on health and environment in sustainable development to which the Polish delegate had referred would be published in June 1997, immediately before a special session of the United Nations to review implementation of Agenda 21 five years after the United Nations Conference on Environment and Development, held in Rio de Janeiro. The report would emphasize current knowledge about the links and analyse actions that had been taken.

A number of delegates had requested information on the management of hazardous, municipal and industrial wastes. That was a serious health issue, which should be tackled intersectorally within the context of healthy cities and healthy villages. WHO would be pleased to support those countries in addressing the problem. In response to the delegate of Zambia, he said that radionuclide contamination of food was a grave matter. It would be necessary to determine the origin of the contamination. If it were related to nuclear waste, the problem would be the responsibility of the International Atomic Energy Agency; if it were related to food, the problem should be addressed within the specific programme on food safety and the programme on environmental health, which included environmental radiation.

Appropriation section 5: Integrated control of disease

Programme 5.1 (Eradication/elimination of specific communicable diseases)
Programme 5.2 (Control of other communicable diseases)
Programme 5.3 (Control of noncommunicable diseases)

Professor ABERKANE (representative of the Executive Board) said that in considering appropriation section 5, the Executive Board had noted with satisfaction the increase in allocations to priority programmes 5.1 and 5.2. It had stressed the importance of availability of suitable national institutions such as laboratory services, disease surveillance and, where appropriate, WHO collaborating centres. The growing problem of emerging and re-emerging diseases and the related problem of antibiotic resistance were areas in which WHO was well placed to undertake prevention and control, as the progress made in the control of the current tuberculosis pandemic well illustrated. In order for progress to be made in other areas, however, more resources must be mobilized on the basis of confirmed political will at the national and regional levels and

by exploiting special events such as World Tuberculosis Day to improve public awareness. The same could be said of the situation with HIV/AIDS: WHO must continue to demonstrate its commitment to dealing with the problem within the framework of UNAIDS.

The Board had also noted the worldwide growth of noncommunicable diseases and the need for WHO to prepare to face new challenges. It had been pointed out that programme 5.3 would face many problems of prevention, particularly with the link between noncommunicable diseases and cancer. A successful battle against noncommunicable diseases connected with lifestyles could be waged through an integrated approach, which was the foundation of the international strategy currently being formulated. Serious attention must continue to be given to that issue in all countries where socioeconomic and demographic change contributed to epidemiological evolution and resulted in rapid growth in morbidity and mortality attributable to chronic noncommunicable diseases, particularly cardiovascular diseases.

Dr AL-JABER (Qatar) said his country was proud of the fact that no new cases of poliomyelitis had been recorded in recent years, thanks to a comprehensive vaccination campaign. No cases of tetanus had emerged, either, because of appropriate health measures adopted. Steps had been taken to combat measles and ensure the vaccination of children under the age of five, but since some cases had been observed in children over five, a policy had been adopted to deal with that problem. A few tuberculosis cases had been recorded, something that undoubtedly was linked to the fact that Qatar, as one of the Gulf States, was a major receiving country for foreign workers. A number of associations had been set up to deal with chronic noncommunicable diseases like diabetes and cancer. It was WHO's responsibility to help Qatar overcome its problems with communicable and noncommunicable diseases, and his delegation welcomed all efforts undertaken by the Organization for that purpose.

Dr SIKOSANA (Zimbabwe) thanked WHO for providing countries of greatest need with both leadership and technical assistance in the control of communicable diseases. In Zimbabwe, much had been done to prevent and control poliomyelitis and neonatal tetanus, with satisfactory results, but efforts to combat HIV/AIDS, tuberculosis and malaria were thwarted by a lack of resources. Despite concerted efforts, more than 700 000 cases of malaria had been recorded during the most recent season, with over 2000 deaths. The number of tuberculosis cases had more than tripled between 1989 and 1996, obviously as a result of the HIV/AIDS pandemic. While Zimbabwe was grateful for WHO's assistance, it believed a more coordinated, global effort was necessary. It therefore called upon all bilateral and multilateral agencies to rally and provide much-needed assistance for the prevention and control of communicable diseases in the countries of greatest need. A regional approach to the problem seemed to be the most cost-effective way of proceeding.

The importance of an effective epidemic surveillance system could not be overemphasized. Countries in greatest need could benefit from the expansion of electronic mail to expedite data transfer in order to develop and monitor the response to epidemics. Neglecting communicable diseases on the grounds that they were largely confined to developing countries alone was not a viable option in today's "global village".

The availability of hepatitis B vaccine in countries with high prevalence of the disease was limited by its high cost. He would therefore welcome information on progress with the quadruple vaccine containing DPT and hepatitis B vaccine.

Dr HAJAR (Yemen) said his country believed that vaccination campaigns were of paramount importance and had accordingly held a number of vaccination days in 1996, spurred by the political will of its leadership and with the benefit of financial support from the Regional Office for the Eastern Mediterranean, for which it was grateful. A donors' meeting would be held in the near future to encourage donors to fulfil their obligations for poliomyelitis control. The concerted efforts made by the Regional Office and Member States in the Region had helped to stem the spread of malaria following an unusually heavy rainy season. There was a need for additional resources, especially in the least developed countries, to enable them to implement vaccination programmes.

Mr CHAUHAN (India) said that, although dracunculiasis had long been a serious problem in India, the number of cases had dropped from 40 000 in 1984, when the national eradication programme had been

launched, to only nine in 1996, and there was reason to hope that there would be no cases in 1997. An international evaluation of India's programme had been undertaken in 1996, mobilizing a team of international experts from WHO and UNICEF as well as national experts; it had concluded that transmission had been interrupted in most endemic villages. Action was now being initiated to obtain certification from WHO's International Commission for the Certification of Dracunculiasis Eradication; for that purpose, surveillance was being extended country-wide by the inclusion of dracunculiasis in the list of diseases reported by each state, the national media were being mobilized for reporting on cases, and a nationwide search for cases was being actively undertaken.

Tuberculosis remained a major challenge, with 14 million cases, to which were added 1.5 million new cases annually. The Government had mapped out a new strategy - based on the evaluation of these pilot projects - emphasizing the cure of infectious and seriously ill patients through administration of supervised short-course chemotherapy to achieve a cure rate of at least 85% and augmentation of case-finding activities. The World Bank had provided funding in the amount of US$ 142 million for activities connected with the strategy. The strategy would be applied over five years, initially in a limited geographical area and for a population of 271 million, with gradual extension to cover the entire country.

Noteworthy success had been achieved in the leprosy control programme. The figure of 4 million cases in 1981, when multidrug therapy had commenced, had been reduced to 0.68 million by 1995, and the prevalence rate had declined from 57 per 10 000 to just over 6.02 per 10 000 by January 1997. Full assistance for the project was being provided by WHO and the World Bank. At the current rate of progress it was more than likely that by the year 2000, leprosy would be eliminated as a public health problem in India.

Poliomyelitis had been a major problem until a "pulse" immunization programme had been launched in 1995. In December 1996, doses had been administered to 120 million children, and in January 1997, to 130 million. Since the start of the programme, more than 430 million children had been covered. The number of cases of poliomyelitis was coming down drastically and made it possible to expect that the disease could be eradicated.

Under a universal immunization programme begun in 1985, about 25 million infants were vaccinated before reaching one year of age with three doses of DPT vaccine, three of poliomyelitis vaccine and one each of measles and BCG vaccine every year. About 27 million women were given two doses of tetanus toxide as prevention against tetanus. The programme was moving along well, as attested to by the fact that the infant mortality rate, which in 1985 had been 129 [per 100 000 live births], had now dropped to 73.

Ms FIGUEROA (Honduras), referring to the transmission of Chagas disease, congratulated the Governments of Argentina, Brazil, Bolivia, Chile, Paraguay and Uruguay for the initiatives that they had taken in the Southern Cone and the impressive progress they had made with regard to the disease. Her country had proposed a similar initiative to eliminate Chagas disease, in Central America, where it was a problem of increasing magnitude. A meeting would be held in Tegucigalpa to develop control and surveillance activities and set the objectives to be achieved over the next five years. At the ninety-ninth session of the Executive Board, the member designated by Honduras had raised the question of the submission of a report on the possible elimination of Chagas disease to the Board or the World Health Assembly in 1998.

She also stated that HIV/AIDS was a matter of growing importance in her country, which affected the economically active population and the population of reproductive age. It was resulting in increased mortality among young people and a rise in the number of children infected with AIDS through their parents and of orphans whose parents had died of AIDS. Although great efforts had been made, her country required better collaboration and fuller knowledge of the activities of UNAIDS in order to help it achieve better results. She was not convinced that her country was receiving the necessary assistance at the present time. She added that one important aspect of the re-emergence of tuberculosis was its relationship with AIDS. The fact that 25% of the AIDS patients suffered from tuberculosis was causing great difficulties.

Professor LEOWSKI (Poland) said programme 5.3 dealt with chronic diseases that in many instances were attributable to demographic transition - increases in life expectancy - and for which in many instances

there was no cure. His country therefore agreed with the emphasis placed on prevention, since proper action in respect of health promotion, lifestyles and behavioural changes could prevent such diseases.

In connection with programme 5.2, he noted that not only humans but also pathogens evolved. More than 25 new pathogens had been identified over the past two decades, and humans themselves were often responsible for their appearance. Tropical diseases were not restricted to the tropics: with the ease of travel in the contemporary world, they could reach any country within hours. Vigilance and proper and early diagnosis were crucial. Programme 5.2 seemed not to give adequate attention to the importance of securing diagnostic facilities, not only for tropical diseases, but also for tuberculosis.

Dr MALYSEV (Russian Federation) said his delegation endorsed the basic thrust and strategic priorities outlined under appropriation section 5 and, in particular, supported the idea of strengthening the control of emerging and re-emerging communicable diseases. WHO's warnings about the growing danger represented by communicable diseases struck a respondent chord in the Russian Federation, which considered that the goal of improving the system for global monitoring of communicable diseases was fully justified. It had substantial experience in that area and was prepared to expand its cooperation with and provide full support for WHO. Priority should be given to such diseases as tuberculosis, with improvement of the approach to treatment of the disease using close surveillance and immunization. Equal attention must be paid to HIV/AIDS and sexually transmitted diseases, hepatitis B virus and the Expanded Programme on Immunization.

He welcomed the emphasis in programme 5.3 on integrated control of noncommunicable diseases, but found the magnitude of that objective to be incompatible with the proposed reduction in financial resources for the programme, both at global level and in three specific regions. If, as seemed likely, the proposed programme budget had been drawn up before completion of *The world health report 1997*, the dichotomy should be rectified. In view of the strong interest shown by many delegations in the conclusions of that report, the Secretariat should consider elaborating a strategy for integrated prevention of chronic noncommunicable diseases, with a view to its consideration by the Executive Board.

More stress should be laid, in WHO's activities for 1998-1999, on attracting additional extrabudgetary resources for the solution of certain health problems linked to noncommunicable diseases, such as cardiovascular disease, cancer, diabetes and genetically transmitted diseases and, in general, for an integrated approach to the prevention and control of noncommunicable disease.

Ms HERZOG (Israel) recalled that most noncommunicable diseases were man-made and therefore preventable, yet they killed millions of people in what the proposed programme budget described as neglected epidemics. Over the years, WHO and its Member States had engaged in a variety of activities in relation to tobacco, alcohol, drugs, diabetes, nutrition and physical exercise; some progress had been achieved, but overall, the effort involved had outweighed the results. The time had perhaps come to ask why the results were not good enough and to try something different. Stemming such epidemics required behavioural change, which was notoriously difficult to bring about. Nevertheless, in view of the budgetary constraints under which WHO operated, it might be better to group the various headings together and make a concerted effort to change behaviours. That would require WHO developing the most effective methodology for the introduction and acceptance of health-promoting lifestyles. To that end, it would be particularly important to invest in the young and work with and through the young. They needed to be involved from the initial stages of development and planning through to the implementation of the relevant activities. Only the young could influence the young. The training of trainers among the young had already proved effective and should therefore be expanded and intensified in order to develop global youth leadership for health promotion.

Dr MAJORI (Italy) said that his delegation placed programmes 5.1 and 5.2 high among WHO's priorities. Although well-satisfied with the work and leadership of WHO in combating communicable diseases, his delegation was nevertheless concerned at the budgetary restrictions affecting some aspects of the work and requested the Director-General to ensure that the necessary financial resources were provided to implement the planned reorganization of the Division of Control of Tropical Diseases, particularly regarding malaria surveillance and control. Despite repeated resolutions, malaria was giving rise to increasing concern

in old and new endemic areas. The requisite action was still hampered owing to insufficient funds and unclear lines of responsibility between headquarters, regional offices and Member States.

Professor NURUL ANWAR (Bangladesh) commended the allocation of additional regular budget resources for the eradication or elimination of specific communicable diseases, such as poliomyelitis, leprosy and neonatal tetanus. However, he expressed concern at the transfer of funding from programme 5.2 to programme 5.1. Although the infant mortality rate and the maternal mortality rate had declined substantially over recent years, they were still very high in his country and his region. Priority attention should continue to be given to national programmes for vaccination against preventable diseases and for immunization and disease surveillance programmes. Additional support would also be needed for national programmes to deal with the emergence or re-emergence of malaria, leishmaniasis and HIV/AIDS. Despite the budgetary constraints, he therefore urged WHO to continue to ensure adequate resource allocation to the above activities.

Dr SULEIMAN (Malaysia), referring to programme 5.2, called for greater attention to be given to dengue haemorrhagic fever, which was now occurring in many countries of the world. He acknowledged that publications on dengue surveillance and control were available and were helpful and thanked the Regional Office for the Western Pacific for its support in dealing with outbreaks of dengue haemorrhagic fever in the Region. The prevention and control of the disease required intensive intersectoral collaboration and greater investment in research if the WHO target of reducing the spread of the disease by 1999 was to be achieved.

Dr PARK (Republic of Korea) commended WHO on its substantial achievement in poliomyelitis eradication, vaccines and immunization, and tuberculosis control. Thanking other Member States for supporting the establishment of the International Vaccine Institute in Seoul, he announced that the Korean Government would expand its contribution to those areas of work through investment in the International Vaccine Institute, voluntary contributions to WHO and various bilateral collaboration projects with other developing countries.

He requested clarification about the shortage of standard PPD for tuberculin skin testing. As was the case in many other countries, the Republic of Korea has been using standard PPD supplied through WHO for a long time. However, it had recently encountered some difficulties in its national tuberculosis control programme owing to a shortage of supply. Close communication should therefore be established between WHO, the International Union against Tuberculosis and Lung Disease and other relevant agencies to solve the problem.

Professor MYA OO (Myanmar) recalled that some age-old diseases, such as poliomyelitis, neonatal tetanus and leprosy, were on the verge of eradication in the South-East Asia Region. Others, however, such as malaria which had almost disappeared in the 1970s, had re-emerged. Moreover, new diseases such as cholera and HIV/AIDS had appeared. In Myanmar, the expanded programme on immunization with six antigens, including OPV, had been very successful and had resulted in a significant reduction in the morbidity and mortality caused by the six target diseases. A recent meeting had been held of officials from Myanmar and China concerning poliomyelitis surveillance and he was confident that poliomyelitis and leprosy would be eliminated from Myanmar by the year 2000.

Dengue haemorrhagic fever was endemic in the country and a policy of health education, environmental management and training was being adopted to combat it. The principal health problem, however, was malaria. In accordance with the global malaria control strategy, national efforts were being concentrated on early diagnosis and prompt treatment for the prevention and control of epidemics. A high-level committee had been established for mosquito control, with emphasis being placed on environmental management and a mass campaign, with the collaboration of nongovernmental organizations, for the elimination of breeding sites.

In conclusion, he stated that the role of WHO in providing essential technical and logistical assistance was highly valued. He therefore hoped that the Organization would continue to play a key role in strengthening the capabilities of Member States and would continue to intensify its efforts to combat communicable diseases wherever they were endemic.

Dr ITO (Japan) welcomed the proposed increase in the budget allocation for programmes on emerging and re-emerging infectious diseases. However, in view of the great importance of the problem of infectious diseases worldwide, and taking into account the modest size of the initial budget allocation, his country would welcome continuing efforts to ensure sufficient funding in future budget discussions.

With regard to the global efforts to combat HIV/AIDS, he noted that UNAIDS had been established as a successor to the Global Programme on AIDS (GPA) in January 1996. WHO was an influential cosponsor of UNAIDS and was expected further to promote its programme activities in HIV/AIDS-related areas. In so doing, it should play a strong promotional and coordination role and liaise with the relevant organizations, including UNAIDS. He therefore requested a clarification concerning the budget allocations for those important activities, with and without staff costs.

Referring to the decision to transfer 2% of the headquarters budget to country programmes of high priority, half of which would be used for HIV/AIDS-related programmes, he commented that the simple redistribution of those funds to the Regional Offices did not seem appropriate. Deliberations were needed at headquarters level to coordinate the activities to be conducted with the reallocated funds with those of other WHO programmes and of other United Nations bodies. He requested clarification as to whether sufficient budgetary allocations would be made for such coordination work.

Finally, he requested clarification of the reason for the apparent decrease in the allocation for specific programme 5.2.6 (Control of tropical diseases), recalling that a similar question put by a member of the Executive Board in January had not received an adequate answer. He understood that a number of draft resolutions were being proposed to strengthen WHO's activities in the control of tropical diseases, which he considered to be a very important area of work.

Professor WHITWORTH (Australia) recalled that *The world health report 1997* focused on noncommunicable diseases and stated that, while health status globally was improving, it was still very poor in the least developed countries and was actually declining in some countries. She added that two of the Executive Board's priorities under appropriation section 5 were the eradication or elimination of specific communicable diseases and the control of other communicable diseases. Those activities were at the core of WHO's mandate; underpinned by research, they were areas in which WHO could make an extraordinary impact through activities that were often very cost-effective. She therefore welcomed the shift in resources towards programmes 5.1 and 5.2, and would have liked to have seen a similar effort in other priority areas.

Dr SILWAMBA (Zambia) gave full support for the concept of an integrated approach to disease control as a prerequisite for the cost-effectiveness and sustainability of health services. However, he expressed concern about the manner in which the concept of integration was described in appropriation section 5 and the manner in which the concept was implemented in practice. In effect, traditional vertical programmes were being repackaged into new forms and disguised as "integrated" programmes. While commending the work of many programmes and specialized units of WHO in developing and updating guidelines, norms and technical standards, he believed that the Organization was not living up to its declared intention of promoting integration, particularly through comprehensive primary health care systems and effective public health infrastructures. What was happening in reality was that those systems were being undermined and weakened. The meagre human, financial and institutional resources in those systems were being diverted from other primary health care purposes to current "integrated" programmes. The best staff in primary health care systems were frequently being attracted by supporting organizations, which often provided better pay and conditions.

In its efforts to strengthen its health delivery systems, particularly as regards primary health care, Zambia had met with reluctance from some of its partners to participate fully in the approach that it was adopting. In particular, WHO and UNICEF advocated the maintenance of vertical programmes, probably as a result of the way in which they prepared their budgets and resource allocations. There was therefore a danger that some activities might actually be contributing to the collapse of health care systems in the developing world. Indeed, the history of attempts to strengthen health care in developing countries was strewn with well-intentioned but failed programmes. He therefore urged the delegates to bear in mind, as they called for the allocation of more resources under appropriation section 5, that the activities involved

might be achieving the opposite of their intended effect. He acknowledged that many WHO programmes had developed useful standards, guidelines and training materials which, with some adaptation, could be used to strengthen integrated health services. In addition, some WHO programmes, and particularly maternal and reproductive health, had foreseen the problems and had worked with his country in an attempt to deverticalize health programming. He therefore supported a more integrated approach to health service delivery.

The meeting rose at 12:30

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