WHA57/2004/REC/2

WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY

GENEVA, 17-22 MAY 2004

VERBATIM RECORDS OF PLENARY MEETINGS AND LIST OF PARTICIPANTS

CINQUANTE-SEPTIÈME ASSEMBLÉE MONDIALE DE LA SANTÉ

GENÈVE, 17-22 MAI 2004

COMPTES RENDUS IN EXTENSO DES SÉANCES PLÉNIÈRES ET LISTE DES PARTICIPANTS

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PREFACE

The Fifty-seventh World Health Assembly was held at the Palais des Nations, Geneva, from 17 to 22 May 2004, in accordance with the decision of the Executive Board at its 112th session. Its proceedings are issued in three volumes, containing, in addition to other relevant material:

Resolutions, decisions and annexes – document WHA57/2004/REC/1

Verbatim records of plenary meetings, list of participants – document WHA57/2004/REC/2

Summary records of committees, reports of committees – document WHA57/2004/REC/3

For a list of abbreviations used in these volumes, the officers of the Health Assembly and membership of its committees, the agenda and the list of documents for the session, see preliminary pages of document WHA57/2004/REC/1.

In these verbatim records, speeches delivered in Arabic, Chinese, English, French, Russian or Spanish are reproduced in the language used by the speaker; speeches delivered in other languages are given in the English or French interpretation. The texts include corrections received up to 13 August 2004, the cut-off date announced in the provisional version, and are thus regarded as final.

AVANT-PROPOS

La Cinquante-Septième Assemblée mondiale de la Santé s'est tenue au Palais des Nations à Genève du 17 au 22 mai 2004, conformément à la décision adoptée par le Conseil exécutif à sa cent douzième session. Ses actes paraissent dans trois volumes contenant notamment :

les résolutions et décisions et les annexes qui s'y rapportent – document WHA57/2004/REC/1,

les comptes rendus in extenso des séances plénières et la liste des participants – document WHA57/2004/REC/2,

les procès-verbaux et les rapports des commissions – document WHA57/2004/REC/3.

On trouvera dans les pages préliminaires du document WHA57/2004/REC/1 une liste des abréviations employées dans la documentation de l'OMS, l'ordre du jour et la liste des documents de la session ainsi que la présidence et le secrétariat de l'Assemblée de la Santé et la composition de ses commissions.

Les présents comptes rendus in extenso reproduisent dans la langue utilisée par l'orateur les discours prononcés en anglais, arabe, chinois, espagnol, français ou russe, et dans leur interprétation anglaise ou française les discours prononcés dans d'autres langues. Ces comptes rendus comprennent les rectifications reçues jusqu'au 13 août 2004, date limite annoncée dans leur version provisoire, et sont donc considérés comme finals.

สิ่งพิมพ์รัฐบาล

สมบัติห้องสมุดรัฐสภา

ПРЕДИСЛОВИЕ

Пятьдесят седьмая сессия Всемирной ассамблеи здравоохранения проходила во Дворце Наций в Женеве с 17 по 22 мая 2004 г. в соответствии с решением Исполнительного комитета, принятым на его Сто двенадцатой сессии. Материалы сессии публикуются в трех томах, в которых, помимо других документов, содержатся:

Резолюции, решения и приложения - документ WHA57/2004/REC/1

Стенографический отчет о пленарных заседаниях и список участников - документ WHA57/2004/REC/2

Протоколы заседаний комитетов, доклады комитетов - документ WHA57/2004/REC/3

Список сокращений, используемых в этих изданиях, и перечень должностных лиц Ассамблеи здравоохранения, так же как и членский состав Комитетов, повестка дня и список документов для данной сессии, приводятся в начале документа WHA57/2004/REC/1.

В стенограммах заседаний выступления на английском, арабском, испанском, китайском, русском и французском языках приводятся в оригинале; выступления на других языках даны в переводе на английский или французский языки. Указанные тексты включают исправления, полученные Секретариатом до 13 августа 2004 г., как о том было объявлено в предварительных протоколах, и потому настоящая редакция считается окончательной.

INTRODUCCIÓN

La 57ª Asamblea Mundial de la Salud se celebró en el Palais des Nations, Ginebra, del 17 al 22 de mayo de 2004, de acuerdo con la decisión adoptada por el Consejo Ejecutivo en su 112ª reunión. Sus debates se publican en tres volúmenes que contienen, entre otras cosas, el material siguiente:

Resoluciones y decisiones, y anexos: documento WHA57/2004/REC/1

Actas taquigráficas de las sesiones plenarias y lista de participantes: documento WHA57/2004/REC/2

Actas resumidas de las comisiones y de las mesas redondas e informes de las comisiones: documento WHA57/2004/REC/3.

En las páginas preliminares del documento WHA57/2004/REC/1 figuran una lista de las siglas empleadas en estos volúmenes, la composición de la Mesa de la Asamblea y de sus comisiones, el orden del día, y la lista de documentos de la reunión.

En las presentes actas taquigráficas los discursos pronunciados en árabe, chino, español, francés, inglés o ruso se reproducen en el idioma utilizado por el orador. De los pronunciados en otros idiomas se reproduce la interpretación al francés o al inglés. Las actas contienen las correcciones recibidas hasta el 13 de agosto de 2004, fecha límite anunciada en la versión provisional, y por consiguiente se consideran definitivas.

مقدمة

انعقدت جمعية الصحة العالمية السابعة والخمسون في قصر الأمم بجنيف في الفترة من ١٧ إلى ٢٢ أيار/ مايو ٢٠٠٤، طبقاً لما قرره المجلس التنفيذي في دورته الثانية عشرة بعد المائة، وتنشر محاضرها في ثلاثة مجلدات تتضمن، بالإضافة إلى بعض المواد الأخرى ذات الصلة، ما يلي:

القرارات والمقررات الإجرائية والملاحق وقائمة المشتركين العرب - الوثيقة جص ع٥٧/٢٠٠٤/ سجلات/١،

المحاضر الحرفية للجلسات العامة وقائمة بأسماء المشتركين - الوثيقة جص ع٥٧/٢٠٠٤/ سجلات/٢

المحاضر الموجزة وتقارير اللجان والموائد المستديرة الوزارية - الوثيقة جص ع٥٧/٢٠٠٤/ سجلات/٣.

وللاطلاع على قائمة الاختصارات المستخدمة في وثائق المنظمة وأعضاء مكتب جمعية الصحة وعضوية لجانها وجدول أعمال الدورة وقائمة بوثائقها، انظر الصفحات التمهيدية للوثيقة جص ع٥٧/٢٠٠٤/ سجلات/١ (النص الإنكليزي).

وترد الكلمات التي ألقيت بالعربية أو الصينية أو الإنكليزية أو الفرنسية أو الروسية أو الأسبانية في هذه المحاضر الحرفية باللغة التي تكلم بها المتحدث؛ أما الكلمات التي ألقيت بلغات أخرى فترد ترجمتها الإنكليزية أو الفرنسية. وهي تتضمن التصويبات التي تم تلقيها حتى ١٣ آب/ أغسطس ٢٠٠٤، وهو الموعد النهائي المعلن في النسخة المؤقتة، وهي بالتالي تعتبر نهائية.

序　言

根据执行委员会第一一二届会议的决定，第五十七届世界卫生大会于 2004 年 5 月 17 日至 22 日在日内瓦万国宫举行。会议记录分三卷出版。除其它有关材料外，其内容包括：

决议、决定和附件 - 文件 WHA57/2004/REC/1

全体会议逐字记录及与会人员名单 - 文件 WHA57/2004/REC/2

各委员会摘要记录及各委员会报告 - 文件 WHA57/2004/REC/3

各卷中使用的缩写清单、卫生大会的官员及其各委员会的组成、议程及会议文件清单，见文件 WHA57/2004/REC/1 先行页。

阿拉伯文、中文、英文、法文、俄文或西班牙文发言的逐字记录，用发言人使用的语言刊载；其它语言的发言用英文或法文译文刊载。这些记录只采纳了 2004 年 8 月 13 日以前收到的更正，这是临时文本中宣布的截止日期，因而它们是最后的文本。

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COMPTES RENDUS IN EXTENSO DES SEANCES PLENIERES

FIRST PLENARY MEETING

Monday, 17 May 2004, at 10:00

President: Dr Khandaker Mosharraf HOSSAIN (Bangladesh)
later: Mr Muhammad Nasir KHAN (Pakistan)

PREMIERE SEANCE PLENIERE

Lundi 17 mai 2004, 10h

Président: Dr Khandaker Mosharraf HOSSAIN (Bangladesh)
puis: Mr Muhammad Nasir KHAN (Pakistan)

1. OPENING OF THE ASSEMBLY
OUVERTURE DE L'ASSEMBLEE

The PRESIDENT:

The Health Assembly is called to order. Director-General, honourable ministers, distinguished delegates, ladies and gentlemen, as President of the Fifty-sixth World Health Assembly, I have the honour to open the Fifty-seventh World Health Assembly.

I now have pleasure in welcoming, on behalf of the Assembly and the World Health Organization, our special guests: Mr Serguei Ordzhonikidze, Director-General of the United Nations Office at Geneva, Mr Pierre-François Unger, Counsellor of State, Head of the Department of Social Action and Health of the Republic and Canton of Geneva, and officials of the Republic, Canton, City and University of Geneva, and of agencies and funds of the United Nations system. I also welcome the representatives of the Executive Board.

2. ADDRESS BY THE REPRESENTATIVE OF THE SECRETARY-GENERAL OF THE UNITED NATIONS
ALLOCUTION DU REPRESENTANT DU SECRETAIRE GENERAL DE L'ORGANISATION DES NATIONS UNIES

The PRESIDENT:

Mr Ordzhonikidze, representing the Secretary-General of the United Nations, will now address the Health Assembly.

Mr ORDZHONIKIDZE (Under-Secretary-General of the United Nations, Director-General of the United Nations Office at Geneva, representing the Secretary-General of the United Nations):

Thank you, Mr President. Mr President, Mr Director-General, excellencies, ladies and gentlemen, it is a pleasure to welcome you to the Palais des Nations today. It is my privilege to convey to you the best good wishes of the United Nations Secretary-General, Mr Kofi Annan, for a successful and productive Fifty-seventh World Health Assembly.

Improving public health is a key concern for the wider United Nations family. The United Nations General Assembly at its fifty-eighth session, adopted an unprecedented number of resolutions on health-related issues. This is a reflection of the close linkages between health and the wider United Nations agenda for peace, security and development. Securing better health and adequate access to health care are key components of the Millennium Development Goals, agreed to by world leaders in 2000 as a blueprint for building better lives for people everywhere in the world in the twenty-first century. The decisions and policies adopted at this World Health Assembly will contribute enormously towards realizing these Goals. As you know, in 2005, the United Nations General Assembly will review our collective progress towards meeting these key Goals, and your Health Assembly's input into this review in the area of health will be very important.

The agenda before this Health Assembly reflects both long-standing and emerging concerns of the international community in the public health area. The international community is on the brink of eradicating poliomyelitis through a concerted, collective effort. At the same time, outbreaks of severe acute respiratory syndrome and avian influenza continue to cause concern. Malaria and tuberculosis, together with HIV/AIDS, decimate communities across the world every year. Every life lost is a personal tragedy, which also has wider economic, social and political implications. We cannot afford to be complacent.

At this Health Assembly, you will focus particular attention on HIV/AIDS. Addressing this global epidemic is the world's most pressing public health challenge and a devastating obstacle to development. Combating the spread of HIV/AIDS, and ensuring affordable treatment for those affected, is a priority for the whole United Nations system. This pandemic is one that the United Nations Secretary-General, Kofi Annan, is personally committed to fighting. On 15 January of this year, he launched a media initiative on HIV/AIDS to raise awareness about the disease – especially among younger people.

WHO's "3 by 5" initiative is an ambitious and far-reaching effort to provide three million people in developing countries with antiretroviral therapy by 2005. The United Nations General Assembly welcomed the initiative at its recent session. Inclusive partnerships are essential to achieve the "3 by 5" aim. National governments, international organizations and civil society must combine their efforts. The United Nations system-wide effort through UNAIDS is an example of how all parts of the United Nations pool knowledge and resources for a comprehensive strategy in the fight against HIV/AIDS.

You will also focus attention on the devastating human, social and economic consequences of the more than 1.2 million deaths in road traffic accidents worldwide every year. Between 20 and 50 million or more people are seriously injured in such incidents every year, often resulting in disability. WHO, the Economic Commission for Europe and others have launched valuable campaigns for road safety, drawing attention to the dreadful consequences of road traffic injuries and calling for

action to prevent these millions of needless deaths and injuries. It is my hope that this Health Assembly will add further impetus to those initiatives.

Mr President, ladies and gentlemen, we face a combination of well-known and fresh challenges in the area of public health. But, we should not lose sight of the fact that technological and scientific advances have also brought unparalleled opportunities for improved health care. It is our duty to seize those opportunities and to make them available to all.

I wish you a very successful Fifty-seventh World Health Assembly.

3. ADDRESS BY THE REPRESENTATIVE OF THE CONSEIL D'ETAT OF THE REPUBLIC AND CANTON OF GENEVA
ALLOCUTION DU REPRESENTANT DU CONSEIL D'ETAT DE LA REPUBLIQUE ET CANTON DE GENEVE

M. UNGER (représentant du Conseil d'Etat de la République et Canton de Genève) :

Monsieur le Président, Monsieur le Directeur général, Excellences, Mesdames et Messieurs les Ministres, Mesdames et Messieurs les Ambassadrices et Ambassadeurs, Mesdames et Messieurs les délégués, Mesdames et Messieurs, à l'occasion de cette Cinquante-Septième Assemblée mondiale de la Santé, j'ai le plaisir et l'honneur de vous souhaiter, au nom des autorités fédérales, cantonales et communales, la bienvenue à Genève et en Suisse.

Une nouvelle fois, et c'est bien normal, votre Assemblée devra se pencher sur la problématique du VIH/SIDA. Plus de 20 ans-25 ans après son apparition, ce fléau constitue tout à la fois un des risques majeurs en matière de santé et un des problèmes les plus épineux en matière de santé publique. Cette épidémie a frappé Genève plus tôt et plus fort que certains autres endroits de la planète. Après une progression fulgurante les premières années, le nombre d'infections à VIH nouvellement détectées a nettement diminué entre 1990 et 1998, puis s'est malheureusement stabilisé. La très grande majorité des homosexuels, première catégorie de la population à Genève à être frappée par la maladie, a adopté des comportements préventifs dès la fin des années 80. Ce fait est remarquable car l'utilisation du préservatif, vous le savez, était pratiquement nulle dans ces milieux il y a 20 ans encore. Cependant, les efforts spécifiques de prévention du SIDA auprès de cette population doivent être maintenus, mais surtout ils doivent être renouvelés, puisque la prévalence du VIH y reste élevée (10 % environ de la population des homosexuels) et que les rapports sexuels entre hommes sont la cause de 30 % des nouvelles infections. L'incidence de l'infection à VIH a en revanche nettement diminué chez les usagers de drogues injectables, suite à la promotion de l'utilisation de matériel d'injection propre, à des programmes de substitution, en particulier par la méthadone, ainsi qu'à des programmes de distribution d'héroïne sous contrôle médical. Par contre, on a constaté une relative hausse ces tout derniers mois des infections propagées par voie hétérosexuelle, et notamment dans certaines populations migrantes. Ces données montrent à quel point l'épidémiologie reste importante afin de permettre de mieux cibler les campagnes de prévention, tout en mettant en évidence la dimension socio-économique de l'infection à VIH/SIDA. Nous pouvons suivre d'ailleurs l'impact de ces campagnes en surveillant un bon indicateur de l'adoption de pratiques sexuelles à moindre risque : c'est l'incidence des autres maladies sexuellement transmissibles. Leur diminution ces dernières années à Genève a été réconfortante, mais l'inversion de cette tendance et l'augmentation en particulier des cas de gonorrhée observées dès 2002 sont préoccupantes.

La généralisation des trithérapies augmente l'espérance de vie des personnes vivant avec le VIH/SIDA. De cela, évidemment, une première conséquence très favorable d'un traitement adéquat : l'absence de particules virales détectables dans le sang diminue sans doute l'infectiosité des personnes séropositives ou malades lorsqu'elles sont sous traitement. Mais il faut mesurer une autre conséquence, négative celle-là, car la trithérapie entraîne peut-être une recrudescence des comportements sexuels à risque, liés, du moins en partie, à un faux sentiment de sécurité et à l'idée que le SIDA serait actuellement guérissable. Bien que l'on ignore l'exactitude de l'impact des traitements anti-VIH sur l'incidence des nouvelles infections, on connaît par contre, et ceci de manière

sûre, leur effet sur l'évolution de la maladie. En Suisse, les trithérapies ont permis de faire chuter l'incidence du SIDA-maladie de 86 % entre 1992 et 1998. Les nouveaux cas de SIDA surviennent le plus souvent chez les patients qui ignorent leur séropositivité, tandis que de plus en plus de décès chez les séropositifs ne sont pas dus au SIDA proprement dit, mais à des pathologies associées, et plus particulièrement à des complications de l'hépatite C. En effet, en l'absence d'une deuxième infection par le virus de l'hépatite C et avec un traitement anti-VIH, la mortalité dans la population VIH-positive s'approche enfin de celle de la population générale. On peut s'attendre à un excès d'environ trois décès pour 1000 personnes et par an, comparé à une surmortalité de plus de 100 pour 1000 en l'absence de traitement. Ainsi, c'est de manière pertinente que l'OMS affirme que « l'accès au traitement antirétroviral est l'un des éléments clés d'une riposte efficace du secteur de la santé face au VIH/SIDA ». Il faut fournir aux personnes les plus vulnérables, d'une manière équitable et qui tienne compte des moyens qui sont les leurs, un traitement antirétroviral efficace, en gardant présente à l'esprit la cible mondiale fixée par l'OMS, qui est d'atteindre un traitement d'au moins trois millions de personnes vivant avec le VIH dans les pays en développement d'ici 2005 ».

Depuis le début de l'épidémie, le Gouvernement genevois a reconnu que le VIH posait non seulement un problème de santé publique mais qu'il incluait de manière majeure des aspects médicaux, sociaux, culturels et légaux. Il a bien sûr, comme tant d'autres, souhaité promouvoir un comportement individuel visant à diminuer les risques de transmission du virus par voie sexuelle ou par voie sanguine, tout en renforçant l'indispensable solidarité entre les personnes séropositives, malades et l'ensemble de la population. En effet, nous assistons trop souvent encore à des attitudes discriminatoires vis-à-vis des personnes atteintes, qui rendent plus difficile le travail de prévention et de prise en charge et créent un climat social inadéquat et stigmatisant.

La lutte contre le SIDA nécessite un partenariat entre pouvoirs publics et associations privées. C'est un des exemples, dans la nouvelle santé publique, d'application de la notion d'*empowerment*, où les patients et leurs proches ont revendiqué avec force leurs droits et ont su prendre leurs responsabilités et influer sur l'avenir. Par ailleurs, la lutte contre cette maladie a rendu nécessaire un élargissement des moyens utilisés, en privilégiant les approches multiples visant essentiellement la diminution des risques et une modification de l'image des politiques en matière d'abus de substances.

Sensibilisé aussi à la gravité de la situation de l'épidémie à travers le monde, le Gouvernement genevois souhaite réitérer son engagement dans la lutte globale contre le SIDA. Il a ainsi récemment adopté une politique en la matière dont un des objectifs vise à « soutenir les projets et les programmes internationaux de l'OMS, de l'ONUSIDA et du Fonds mondial de lutte contre le SIDA, la tuberculose et le paludisme ». C'est donc dans une ville, un canton et un pays dont les différentes autorités sont pleinement conscientes de l'importance de cette problématique que vous pouvez entamer vos travaux. Le VIH/SIDA n'est d'ailleurs pas le seul objet dont les décisions que vous prendrez lors de cette Assemblée vont influencer fortement et durablement l'avenir de milliards de gens : des thématiques comme la *Stratégie mondiale pour l'alimentation et l'exercice physique* peuvent elles aussi avoir un impact majeur sur la santé des habitants de la terre, en agissant sur deux de ses principaux déterminants.

C'est avec une ferme conviction que je vous souhaite la plus chaleureuse bienvenue à Genève et que je vous adresse les meilleurs voeux du Gouvernement pour la réussite de vos travaux.

Je vous remercie de votre attention.

4. ADDRESS BY THE PRESIDENT OF THE FIFTY-SIXTH WORLD HEALTH ASSEMBLY
ALLOCUTION DU PRESIDENT DE LA CINQUANTE-SIXIEME ASSEMBLEE MONDIALE DE LA SANTE

The PRESIDENT:

Now it is my opportunity to address this Fifty-seventh World Health Assembly as the outgoing President. *Bismillah arrahman arrahim.* Director-General, honourable ministers of the Member

countries, excellencies, distinguished delegates, ladies and gentlemen, *Assalamu alaikum* and very good morning. It is indeed a great honour and privilege for me to address the Fifty-seventh World Health Assembly in my capacity as President of the Fifty-sixth World Health Assembly. On behalf of myself and my country, Bangladesh, I wish to thank my colleagues from the Member States who elected me to the presidency last year. As I recall, during the last Health Assembly, several important resolutions were passed including the historic treaty on the WHO Framework Convention on Tobacco Control. I am very happy to note that more than 100 countries have signed the Framework Convention and about 13 countries have already ratified it. The Cabinet of my country has already approved ratification of the Framework Convention last week, which signifies the commitment of Member States to the control of tobacco-related illness and prevention of unnecessary deaths.

As primary health care has been a cornerstone of health policy in our countries, revisiting lessons learnt about the primary health care concept and identifying the future strategic direction for primary health care on the occasion of the twenty-fifth anniversary of the Declaration of Alma-Ata has been very timely. This is even more so because the world is currently in transition. Market economies, increased trade and travel, intellectual property rights, especially on public goods and services as well as the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights, have significant bearing on access to, and equitable distribution of, primary health care, especially to the vulnerable and the poor. Similarly, conflicts, emergencies and natural and man-made disasters impede access to services. Therefore, in the present context, primary health care and health systems should emphasize addressing such issues.

Disease vectors and viruses observe no boundaries: the national and international experiences with SARS made us aware of the need for effective surveillance and strategies such as collaboration among countries, proper infection control measures and coordinated efforts of several sectors, and networks of relevant scientific institutions to maximize our knowledge and capacity to handle such new diseases. To handle new and emerging disease, the most important issues are how to get the relevant information to the most peripheral level health workers and how to increase access to knowledge about preventive and control measures for populations at large. In this context, I reiterate the suggestion which I made in my speech to the Health Assembly last year, that WHO establish a global health channel. Such a television channel, if available, would facilitate implementation of WHO recommended guidelines and preventive measures by the most peripheral health workers and also by people living in remote areas who do not have access to the WHO web site.

I am happy to see that, this year, the attention of the Health Assembly is drawn to the very important subject of road safety and health. This was also the theme of World Health Day 2004. The World Health Day theme has provided an opportunity to focus the world's attention on this very critical and rapidly growing public health problem. Too often in the past, road safety has been treated as a transportation issue and not a health issue. World Health Day 2004 helped to create awareness about road safety as a public health issue. Road traffic accidents ranked ninth in the global burden of disease and are projected to rise to third place if preventive measures are not taken to reverse the trend. However, it will be necessary to sustain the momentum generated by World Health Day. I feel that a day devoted to road safety every year could provide continuity to the process started on World Health Day and would help to slow down the rising trend in road traffic accidents.

I am pleased to see that the draft global strategy on diet, physical activity and health is on the agenda. *The world health report 2002* indicated that mortality, morbidity and disability attributed to major noncommunicable diseases currently account for 50% of all deaths and 47% of the global burden of disease. These figures are on the rise. I hope that the draft global strategy will be adopted and we shall be able to develop and implement actions recommended in this strategy, adapted as appropriate to our national circumstances. We need to promote lifestyles that include a healthy diet and physical activity, and foster energy balance, which will eventually help in reducing the burden of noncommunicable diseases in our countries. I am encouraged to see that the topics discussed in the previous Health Assembly, as well as being discussed during this Health Assembly, contribute to achieving the Millennium Development Goals. Six out of eight Goals and nine out of 18 targets of the Millennium Development Goals are linked to health and health-related areas. The interventions needed to meet these targets call for interrelated health actions: for example, reducing maternal and child mortality cannot be looked at separately because maternal mortality contributes to a high

proportion of child mortality also. Similarly, monitoring and surveillance systems for diseases included in the Millennium Development Goals such as malaria, HIV/AIDS, and tuberculosis contribute to the strengthening of health systems as a whole. Some of the other targets, such as access to improved water supply, dietary energy consumption or using solid fuels, contribute to reducing diarrhoeal disease, acute respiratory infection and malnutrition. Therefore it is important for us to make concerted and coordinated efforts with all related sectors to achieve the Millennium Development Goals. In my own country, we are trying to achieve this within the broader context of a poverty reduction strategy.

In addition to achieving long-term objectives of attaining health for all, the health of populations in crisis situations is also extremely important. Such situations demand urgent action. Population displacement, lack of clean water and sanitation can lead to outbreaks of disease. The collapse of basic health services which is very common in a crisis compounds the severity of public health consequences. Such crises are occurring due to natural disasters and armed conflicts which are present in several parts of the world today. In this context, I would like to take this opportunity to commend WHO for its role in humanitarian response and pay my tribute to WHO and other United Nations staff who lost their lives in Iraq last year during the conflict.

WHO has a challenging and unique task: the six regions of WHO are at various levels of health development and each region is unique in its health needs. In the South-East Asia Region where my country belongs, though the infant mortality rate is decreasing fast, the maternal mortality rate still remains high in all countries. Ten out of 11 countries in the Region have been free of poliomyelitis for several years. We have to work collectively to complete our unfinished agenda.

Before I conclude, I would like to extend my congratulations to Dr Samlee Plianbangchang who has taken over as Regional Director for South-East Asia and wish him a very successful tenure. I hope that under his able leadership the WHO South-East Asia Region will significantly improve health outcomes and declare the Region poliomyelitis-free. Last, but not least, I wish to extend my congratulations to Dr Lee Jong-wook, Director-General of WHO, for successfully completing almost one year in office and for taking several initiatives to reduce the sufferings of humanity and promote health. I would like particularly to congratulate Dr Lee on his commitment and efforts to provide the most needy people with antiretroviral drugs through his "3 by 5" initiative. His efforts to expand directly observed treatment, short course (DOTS) for tuberculosis control in high burden countries of the world and his efforts to interrupt poliomyelitis transmission in the few countries which are still not poliomyelitis-free so that the world can be free of it are very commendable. I wish him every success in his endeavours. Finally I wish the Fifty-seventh World Health Assembly every success.

5. MUSICAL INTERLUDE
INTERLUDE MUSICAL

The PRESIDENT:

As we are all gathered here in the city of Geneva, it would seem very appropriate to enjoy a touch of Swiss culture before we continue with our work. I therefore have great pleasure in announcing that we will now hear two short pieces of music by Mr Olivier Tronchet on the alpenhorn.

A short recital was given.
Un bref récital suit.

The PRESIDENT:

I thank you, Mr Tronchet.

I would now ask our distinguished guests to kindly remain seated while the Health Assembly deals with its first two items which should not take very long.

6. APPOINTMENT OF THE COMMITTEE ON CREDENTIALS
CONSTITUTION DE LA COMMISSION DE VERIFICATON DES POUVOIRS

The PRESIDENT:

We start with provisional agenda item 1.1, "Appointment of the Committee on Credentials". The Health Assembly is required to appoint a Committee on Credentials in accordance with Rule 23 of the Rules of Procedure of the World Health Assembly. In conformity with this Rule, I propose for your approval the following 12 Member States: Austria, Belize, Canada, Djibouti, Gambia, India, Italy, Kenya, Mali, Myanmar, Papua New Guinea, and Uzbekistan.

Is this proposal acceptable?

If there are no comments, I declare the Committee on Credentials, as proposed by me, appointed by the Health Assembly.

7. ELECTION OF THE COMMITTEE ON NOMINATIONS
ELECTION DE LA COMMISSION DES DESIGNATIONS

The PRESIDENT:

We shall now proceed with item 1.2 of our provisional agenda, "Election of the Committee on Nominations". This item is governed by Rule 24 of the Rules of Procedure of the World Health Assembly. In accordance with this Rule, a list consisting of 24 Member States and the President ex officio has been drawn up, which I shall submit to the Health Assembly for its consideration. May I explain that, in compiling this list, the following distribution by region has been applied: Africa: 6 members; the Americas: 5; Eastern Mediterranean: 2; Europe: 6; South-East Asia: 2; and Western Pacific: 3. I therefore propose to you the following Member States: Bahrain, Brunei Darussalam, Burkina Faso, Democratic Republic of the Congo, Eritrea, Estonia, Federated States of Micronesia, France, Guyana, Israel, Mexico, Monaco, Mozambique, Nicaragua, People's Republic of China, Peru, Russian Federation, Sri Lanka, Swaziland, Thailand, Tunisia, Uganda, United Kingdom of Great Britain and Northern Ireland, and Uruguay.

Is this proposal acceptable? In the absence of comments, I declare the Committee on Nominations elected. As you know, Rule 25 of the Rules of Procedure, which defines the mandate of the Committee on Nominations, also states that the proposals of the Committee on Nominations shall be forthwith communicated to the Health Assembly.

I will now suspend the meeting so that the Committee on Nominations may meet in Room 7. As soon as the Committee on Nominations has completed its deliberations, we will resume in plenary. This is expected to take approximately half an hour.

The meeting was suspended at 10:55 and resumed at 11:30.
La séance est suspendue à 10h55 et reprend à 11h30.

8. FIRST REPORT OF THE COMMITTEE ON NOMINATIONS[1] PREMIER RAPPORT DE LA COMMISSION DES DESIGNATIONS[1]

The PRESIDENT:

We shall now consider the first report of the Committee on Nominations. I shall read this report.

The Committee on Nominations, consisting of delegates of the following Member States: Bahrain, Brunei Darussalam, Burkina Faso, China (People's Republic of), Democratic Republic of the Congo, Eritrea, Estonia, France, Guyana, Israel, Mexico, Micronesia (Federated States of), Monaco, Mozambique, Nicaragua, Peru, Russian Federation, Sri Lanka, Swaziland, Thailand, Tunisia, Uganda, United Kingdom of Great Britain and Northern Ireland, Uruguay and Dr Khandaker Mosharraf Hossain (Bangladesh) (ex officio), met on 17 May 2004.

In accordance with Rule 25 of the Rules of Procedure of the World Health Assembly and respecting the practice of regional rotation that has been followed for many years in this regard, the Committee decided to propose to the Health Assembly the nomination of Mr Muhammad Nasir Khan, Health Minister of Pakistan, for the office of President of the Fifty-seventh World Health Assembly.

Is this proposal from the Committee on Nominations acceptable?

Election of the President
Election du Président de l'Assemblée

The PRESIDENT:

In the absence of any observations, and as it appears that there are no other proposals, I suggest, in accordance with Rule 80 of the Rules of Procedure, that the Health Assembly approve the nomination submitted by the Committee and elect its President by acclamation.

(Applause/Appaudissements)

Mr Muhammad Nasir Khan is thereby elected President of the Fifty-seventh World Health Assembly and I invite him to take his seat on the rostrum.

Mr Khan (Pakistan) took the presidential chair.
Mr Khan (Pakistan) prend place au fauteuil présidentiel.

The PRESIDENT:

I should like to thank this august assembly for their trust in electing me as President of the Fifty-seventh World Health Assembly. I would like to express my appreciation to Dr Hossain, my predecessor, for his contribution to the last Health Assembly. I shall deliver the customary address later today and we shall now continue with our work.

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[1] See reports of committees in document WHA57/2004/REC/3.

[1] Voir les rapports des commissions dans le document WHA57/2004/REC/3.

9. SECOND REPORT OF THE COMMITTEE ON NOMINATIONS[1] DEUXIEME RAPPORT DE LA COMMISSION DES DESIGNATIONS[1]

The PRESIDENT:

I now invite the Health Assembly to consider the second report of the Committee on Nominations. I shall read this report.

At its first meeting held on 17 May 2004, the Committee on Nominations decided to propose to the Health Assembly, in accordance with Rule 25 of the Rules of Procedure of the World Health Assembly, the following nominations: Vice-Presidents of the Health Assembly: Dr M.E. Tshabalala-Msimang (South Africa), Mrs A. David-Antoine (Grenada), Mr S. Bogoev (Bulgaria), Dr R. Maria de Araujo (Timor-Leste), Dr Chua Soi Lek (Malaysia).

Committee A: Chairman – Dr Ponmek Dalaloy (Lao People's Democratic Republic).
Committee B: Chairman – Dr Jigmi Singay (Bhutan).

Concerning the members of the General Committee to be elected under Rule 31 of the Rules of Procedure of the World Health Assembly, the Committee decided to nominate the delegates of the following 17 countries: Botswana, Chad, Chile, China (People's Republic of), Cuba, France, Ireland, Kazakhstan, Liberia, Libyan Arab Jamahiriya, Niger, Nigeria, Russian Federation, Trinidad and Tobago, United Kingdom of Great Britain and Northern Ireland, United States of America and Yemen. I invite the Assembly to decide, in order, on the nominations proposed.

Election of the five Vice-Presidents
Election des cinq vice-présidents de l'Assemblée

The PRESIDENT:

We shall begin with the election of the five Vice-Presidents of the Health Assembly. There being no comments, I propose that the Health Assembly declare the five Vice-Presidents elected by acclamation.

(Applause/Applaudissements)

I shall now determine by lot the order in which the Vice-Presidents shall be requested to serve should the President be unable to act in between sessions.

The names of the five Vice-Presidents have been written down on five separate sheets of paper which I am going to draw by lot. Dr Rui Maria de Araujo (Timor-Leste) is the first Vice-President. The second Vice-President is Mrs A. David-Antoine (Grenada). The third is Mr S. Bogoev (Bulgaria). The fourth is Dr M.E. Tshabalala-Msimang (South Africa), and the fifth is Dr Chua Soi Lek (Malaysia). I shall request the Vice-Presidents to come to the rostrum and take their places there.

Election of the Chairmen of the main committees
Election des présidents des commissions principales

The PRESIDENT:

We now come to the election of the Chairman of Committee A. Dr Ponmek Dalaloy (Lao People's Democratic Republic) is proposed as the Chairman of Committee A. Is this proposal

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[1] See reports of committees in document WHA57/2004/REC/3.

[1] Voir les rapports des commissions dans le document WHA57/2004/REC/3.

acceptable? There being no other proposals, I invite the Health Assembly to declare Dr Ponmek Dalaloy elected Chairman of Committee A by acclamation.

(Applause/Applaudissements)

We have now to elect the Chairman of Committee B. Dr Jigmi Singay (Bhutan) is proposed. Is this proposal acceptable? There being no other proposals, I invite the Health Assembly to declare Dr Jigmi Singay elected Chairman of Committee B by acclamation.

(Applause/Applaudissements)

Establishment of the General Committee
Constitution du Bureau de l'Assemblée

The PRESIDENT:

We shall now look at establishing the General Committee. In accordance with Rule 31 of the Rules of Procedure, the Committee on Nominations has proposed the names of 17 countries, the delegates of which, added to the officers just elected, would constitute the General Committee of the Health Assembly. These proposals provide for an equitable geographical distribution of the General Committee. The countries proposed are: Botswana, Chad, Chile, China, Cuba, France, Ireland, Kazakhstan, Liberia, Libyan Arab Jamahiriya, Niger, Nigeria, Russian Federation, Trinidad and Tobago, United Kingdom of Great Britain and Northern Ireland, United States of America, and Yemen. Is this proposed list acceptable? I see that there are no other proposals. Those countries are therefore elected.

The members of the General Committee are the President and the Vice-Presidents of the Health Assembly, the Chairmen of the main Committees, and the delegates of the 17 countries you have just elected.

The meeting rose at 11:50.
La séance est levée à 11h50.

SECOND PLENARY MEETING

Monday, 17 May 2004, at 15:00

President: Mr Muhammad Nasir KHAN (Pakistan)

DEUXIEME SEANCE PLENIERE

Lundi 17 mai 2004, 15 heures

Président: M. Muhammad Nasir KHAN (Pakistan)

1. PRESIDENTIAL ADDRESS
DISCOURS DU PRESIDENT DE L'ASSEMBLEE

The PRESIDENT:

Bismillah arrahman arrahim. Director-General of WHO, honourable ministers, excellencies, distinguished delegates, ladies and gentlemen. *Assalamu alaikum.*

At the outset, let me express my profound gratitude to all of you for having elected me as the President of the Fifty-seventh World Health Assembly. It is indeed a singular honour for Pakistan, as well as for the WHO Eastern Mediterranean Region. I bring the warm greetings of the people of Pakistan to you. I wish to pay special tribute to Dr K.M. Hossain, Minister of Health and Family Welfare of Bangladesh, for providing excellent leadership to the Fifty-sixth World Health Assembly. I would like to register appreciation of the World Health Organization's valuable contribution to the efforts to promote better health conditions for all. I also take this opportunity to extend congratulations to Dr Lee Jong-wook for taking concrete measures and bold initiatives for the realization of these goals since taking over as Director-General of WHO, and assure him of our full support in his endeavours.

At this crucial juncture, humanity is confronted with overwhelming health challenges aggravated by poverty, conflict and war. Against this backdrop, it is heartening to note credible efforts by the World Health Organization to evolve a new global health policy aimed at attaining the cherished goal of "health for all", which has remained our common inspiration since 1979. At the start of the new millennium we affirmed the Millennium Development Goals which, too, envisage targets of drastic reduction in poverty and marked improvements in the health of the poor by the year 2015. Accomplishing these goals would require demonstration of unity of purpose, political resolve and adequate resource mobilization.

Health is a key building block for socioeconomic development. Poor health by itself is a deprivation and an integral part of poverty. It is therefore imperative for all of us to increase our spending on health and ensure the cost-effectiveness of our interventions, as part of an effort to address the existing inequities amongst people. Effective mobilization of communities and intersectoral collaboration is vital for improving health outcomes as evidenced by our experience in several countries in several regions of WHO.

Furthermore, there is a growing realization that women are currently shouldering the greater share of poverty with negative consequences on their health. It is estimated that 70% of 1200 million people living below the poverty line are females. In most developing countries, women are disadvantaged in areas such as education, skills, employment opportunities and mobility, which significantly diminishes their human development capacity and impairs their health status. Consequently, in many developing and poor countries, several major diseases including tuberculosis, malaria and HIV/AIDS, as well as maternal and child ill-health and malnutrition seriously affect the health of women and lead to the perpetuation of poverty. In this context, we welcome the efforts being made through The Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global TB Drug Facility, and the Global Alliance for Vaccines and Immunization, to support national governments.

I would like you to spare a moment for the 40 million people living with HIV/AIDS today, 95% of whom are in the developing countries. WHO and UNAIDS deserve compliments for their initiative to provide antiretroviral therapy to three million AIDS patients in developing countries by the end of the year 2005, and for meticulous execution of this initiative with great precision and through application of important principles of equity, sustainability and urgency. I would be failing in my duty if I did not commend WHO – especially its Director-General, Dr Lee – for the scaling-up of antiretroviral therapy contained in the "3 by 5" initiative which deserves our collective support and appreciation. In this regard, it gives me great personal and professional pleasure to report that, with the cooperation of civil society, later this year Pakistan will be hosting the first Asia-Pacific conference, which can be replicated in other countries.

Despite an increasing awareness of the ethical and safety issues relating to the spread of HIV/AIDS, the majority of developing countries lack a nationally-coordinated or organized safe blood transfusion service. It is estimated that out of more than 75 million units of blood donated each year, less than 40% are safe. At least 13 million units of blood donated each year are not tested for the transmissible viruses. The foregoing clearly identifies the need to have a safe and reliable transfusion service so that a life-giving procedure is not transformed into an eminently life-threatening one.

We need a sustained global effort to control tuberculosis in order to achieve the 2005 global targets of 70% case detection of new sputum smear-positive cases coupled with a treatment success rate of 85%. We cannot ignore the 8.8 million new cases of tuberculosis detected every year, out of which 3.9 million can spread the disease further. We must show a firm resolve to face this challenge and secure a tuberculosis-free environment for our children. Malaria has also affected mankind for centuries through its devastating effects. In 1998, WHO launched the Roll Back Malaria Partnership for a coordinated approach to fight malaria and, with the support of other partners including UNICEF, UNDP and the World Bank, to halve the burden of malaria by the year 2010. We need to coordinate efforts to achieve this target.

As regards poliomyelitis, a disease that has killed or crippled millions of our children in the past, there is an historic opportunity to stop transmission of poliovirus which, if seized, will eliminate the risk of any child ever again experiencing the crippling effects of this devastating disease. Never before has the world been so close to success, with only six countries remaining poliomyelitis endemic; countries which, through their declaration of 15 January 2004, pledged to do all within their control to halt poliovirus transmission in their countries by the end of the year 2004. God willing, with our collective support, we will add another chapter of glory to the history of public health and mankind by eradicating poliomyelitis this year. Other vaccine-preventable illnesses, notably measles and hepatitis B, also warrant our urgent attention.

Developing countries account for 99% of preventable maternal deaths, which exceed half a million every year. Most of these deaths occur due to the absence of skilled health personnel during childbirth, lack of facilities for emergency obstetric care and an ineffective referral system. Similarly, 12.2 million deaths of under-fives in the developing countries amount to 99% of the under-fives' deaths worldwide. Nutritional problems of developing countries include protein-energy malnutrition, micronutrient deficiency resulting in anaemia, vitamin A and iodine deficiency. These conditions, along with reduced exclusive breastfeeding and low birth weight, are often associated with poverty and poor health, and lead to long-term deficits in cognition and school achievement. These wide-scale complacencies need to be effectively addressed. The basic development needs approach, with the

support of the communities and local governments as conceptualized by the WHO Eastern Mediterranean Region, provides an excellent way out of this problem.

Threatened by epidemic proportions of communicable diseases, we should not be complacent in dealing with noncommunicable diseases. Noncommunicable diseases, including cardiac problems, strokes, cancers, rheumatic and respiratory diseases, oral diseases, diabetes, mental health problems and genetic disorders such as thalassaemia and haemophilia, are rampant not only in developed countries but in developing countries as well. Experience clearly shows that countries can reverse the advance of these diseases by appropriate preventive action. Tobacco use causes nearly five million deaths per year. Unless current smoking trends are reversed, the figure is expected to rise to 10 million in 20 years' time. The last Health Assembly unanimously adopted the world's first public health treaty designed to reduce tobacco-related deaths and diseases around the world, requiring countries to adopt a comprehensive strategy for tobacco control.

This brings me to the highly important area of positive lifestyle modification. An indicative list includes placing a comprehensive ban on tobacco advertising, promoting the healthy schools initiative, wearing safety helmets in factories and when riding motorcycles, using seat-belts in cars, taking regular physical exercise, and eating fruits and vegetables to help prevent cardiovascular diseases and some cancers. At present, the excessively motorized way of life results in the killing of more than 1.2 million people on the roads every year, making it the ninth highest killer in the world. I personally had a very tragic accident last year; my father died on a motorway in Pakistan. So this action that has to be taken is very close to my heart. While expressing my gratitude and commending WHO for declaring road safety as its theme for the World Health Day this year, I would call upon all Member States to ratify a convention in order to make the roads safer, saving the loss of people's lives.

Organ and tissue transplantation is a recognized therapy in the world we know today. However, in this regard we need to address the safety, dignity and – above all – ethical issues concerning the donors as well as the recipients and the observance of transparency in all activities related to transplantation. The WTO Agreement on Trade-Related Aspects of Intellectual Property Rights would restrict access of the common man to essential drugs. In this regard, it is encouraging to witness the consensus emerging among the WTO Members on the issue of access to medicines by countries with little or insufficient capacity for pharmaceutical production. It is also good to know that WHO will be working with countries which could make use of the new arrangement to assist them to achieve the full public health benefit from lower prices. Emergency and epidemic preparedness is gaining substantial importance in our everyday lives. I am therefore happy to note that WHO continues to track the evolving infectious diseases situation, sound the alarm when needed, share expertise, and mount the kind of response needed to protect populations from the consequences of epidemics, whatever and wherever their origin.

I always say it and I say it today, wherever there is peace, there is God. I must commend the multidimensional policy and planning framework of the "Health as a bridge for peace" initiative, which supports health workers in delivering health programmes in conflict and post-conflict situations and at the same time contributes to peace-building principles, strategies and practices in health relief and health sector development. The concept is rooted in values derived from human rights and humanitarian principles as well as medical ethics and is supported by the contribution of peace-building strategies in achieving social stability and lasting health gains. The Fifty-first World Health Assembly formally accepted "Health as a bridge for peace" in May 1998, as a feature of the "Health-for-all for the twenty-first century" policy. Subsequently in October 2000, a report stressed the need for mobilizing all relevant resources of the United Nations system and other international actors in support of the activities so they could contribute to peace. Unfortunately events like war, civil strife or violence tend to be highly detrimental in more ways than one to the provision of adequate health services, particularly preventive health care, to the population.

I must impress upon all of you the importance of building environments conducive to health development through the concerted efforts of all sectors including health, through extensive partnership building. We have to reach out to bring together all the stakeholders including bilateral and multilateral donors, other United Nations agencies, the governmental sector other than health, nongovernmental organizations and local communities in order to meet the health challenges that confront the world today. I would urge the developed countries to take note of the critical

recommendation of WHO's Commission on Macroeconomics and Health that lack of donor funds should not be a factor that limits the capacity to provide health services to the world's poorest people. Now, we also talk not about the "Third World" but unfortunately a "Fourth World", even poorer than the Third World. The recent outbreaks of severe acute respiratory syndrome (SARS) and avian influenza have demonstrated to us how epidemics can be rapidly and effectively contained through the concerted efforts of all stakeholders. While we are making every effort necessary to realize our ultimate goal of making the attainment of the highest possible standards of health a living reality in the not-too-distant future, it is imperative to develop and build our strategic vision through these rewarding experiences.

Let me remind the Health Assembly that this great congregation of nations is a tribute to the collective endeavours of the human race to look beyond conflict, beyond disease, beyond ignorance, deprivation and pain to the imperatives of dignity and opportunity to develop, which is the fundamental right of every human being in the world irrespective of his colour, race or religion. The Health Assembly has a global mission born out of this universal vision. It is, therefore, our belief that this Health Assembly should be the meeting-ground of all nations, rich and poor, where concrete steps are taken to reduce the poverty, powerlessness and hopelessness of huge masses of people. This calls for a proactive global health agenda, ensuring the long-term flow of resources to areas of need requiring priority attention. It calls for a translation of the health-for-all vision in terms of higher resource flows, better official development assistance performance, quicker debt relief to deserving nations and a more equitable trade and technology regime. It calls for the bridging of the yawning divides that characterize the world today: the resource gap, the knowledge and technology gap, and more specifically the digital and biotechnology divides working in tandem to the detriment of the poorer nations of the world. Above all, this great Health Assembly is a powerful reminder of the importance of compassion in order to build a safer and a healthier world.

This is our planet, we the human race have to live together on it. We all have one destiny and we have to save our world today, to build a better tomorrow for us and for our children. A world of tolerance, understanding and justice instead of a world of hate, pain, misery and conflicts. Let us bring smiles to our children, whether they are in Africa, Latin America, South-East Asia or the Middle East. Let us bring happiness to our brothers and sisters in the world today.

Nothing is politically right which is morally wrong. We must have the courage to stand up for the truth and work for justice and for health diplomacy which, I believe, is the strongest tool to heal the world and to heal humanity today. I am confident that the Health Assembly, which is the embodiment of the sovereign will of the governments of Member States, will guide WHO forward in a spirit of friendship and common purpose.

I thank you once again for bestowing upon me this honour and wish your deliberations every success. I wish you a very fruitful Fifty-seventh World Health Assembly.

2. ADOPTION OF THE AGENDA AND ALLOCATION OF ITEMS TO THE MAIN COMMITTEES
ADOPTION DE L'ORDRE DU JOUR ET REPARTITION DES POINTS ENTRES LES COMMISSIONS PRINCIPALES

The PRESIDENT:

The first item to be considered this afternoon is item 1.4, "Adoption of the agenda and allocation of items to the main committees", which was examined by the General Committee at its first meeting earlier today.

The General Committee examined the provisional agenda for the Fifty-seventh World Health Assembly, document A57/1, as prepared by the Executive Board and sent to all Member States. Before proceeding to the proposals for supplementary agenda items, I should first like to deal with the provisional agenda as contained in document A57/1. The General Committee recommended that the following items should be deleted from the provisional agenda as there are no corresponding items of

business to deal with under them: item 5, "Admission of new Members and Associate Members" (Article 6 and Rule 115), for which I have been informed no new applications have been received; item 15.4, "Assessment of new Members and Associate Members"; item 15.5, "Amendments to the Financial Regulations", for which no new amendments have been proposed; and item 17.2, "Amendments to the Staff Regulations and Staff Rules", for which no amendments have been proposed. Am I correct is assuming it is agreed to delete these items? As I see no objections, it is so decided.

The General Committee also considered the addition of two supplementary agenda items for which proposals had been received by the Director-General. The first proposal was to include a supplementary agenda item, "Eradication of dracunculiasis". The General Committee decided to recommend to the Health Assembly that it include this item in the agenda. May I assume the Health Assembly agrees with the recommendation of the General Committee to include this item as a supplementary agenda item? I see no objection; the recommendation is therefore approved.

The General Committee also considered the proposal to include a second supplementary agenda item, "Inviting Taiwan to participate in the World Health Assembly as an observer". The General Committee took the same position as at previous Health Assemblies when presented with the same proposal, and recommended that the item should not be included in the agenda. Is this recommendation acceptable to the Health Assembly? Gambia, you have the floor, please.

Dr KASSAMA (Gambia):

Allow me first and foremost to commend the World Health Organization on behalf of the Government of the Republic of the Gambia for the Organization's immense contribution to improving the health and welfare of humanity the world over.

Mr President, you will no doubt agree that good health is important for every citizen of the world and that access to the highest standard of health information and services is necessary to improve public health. Direct and unobstructed participation in international health cooperation forums and programmes is beneficial for all parts of the world, especially today with the greater potential for the cross-border spread of various infectious diseases such as HIV/AIDS, tuberculosis and malaria. Given these established facts, the Government of the Republic of the Gambia strongly and unequivocally supports the candidature of Taiwan as an observer in this Organization.

The population of Taiwan – 23 million human beings – is more than the population of many Member States in this Health Assembly. In fact, it is known that you do not require to be a State or a country to qualify for participation in the Health Assembly as an observer. As the pace of globalization quickens there is a proportionate acceleration of the spread of infectious diseases, as is classically demonstrated by the HIV pandemic and, more recently, the outbreaks of SARS and avian influenza in Asia. These events have prompted WHO's response to strengthen public health. Article 2, paragraph 7 of resolution WHA56.29 on SARS adopted in May 2003 requests the Director-General to respond appropriately to all requests for WHO's support for surveillance, prevention and control of SARS in conformity with WHO's Constitution. This resolution has not, however, been observed by WHO for the people of Taiwan, because four requests made after this resolution were not responded to. It should be noted that the implementation of the Health Assembly resolution needs to be monitored and evaluated. May I also mention that the health care delivery systems and health status of people living across the Taiwan Strait are different, and have no linkages or communication, contrary to what is being claimed here. The active denial of the Taiwanese people's participation in the Health Assembly is affecting not only them but also many Members who could benefit from Taiwan's experience. Taiwan has one of the highest life expectancies and the lowest maternal and infant mortality rates in the world, and has eradicated some communicable diseases that are of major public health concern in developing countries. To demonstrate that lack of communication across the Taiwan Strait, may I mention that presently Taiwan lacks access to several things. It lacks access to the revised International Health Regulations, which are meant to provide security against the international spread of diseases, while of course avoiding unnecessary interference with international traffic. The country should not be excluded from the forum that discusses and updates such regulations in an attempt to protect the global community. Taiwan has the capacity and needs to participate in WHO's Global

Outbreak Alert and Response Network as demonstrated by the efficient surveillance system being implemented at Taiwan's Center for Disease Control in Taipei. Despite the advances in medicine, science and technology, Taiwan does not have access to WHO's network of vaccines and supplies, nor of course to WHO's standards and serum references which ensure quality of laboratory testing in disease control. To participate effectively as a member of the World Trade Organization (WTO), we believe Taiwan needs to have access to Codex. Good health is vital for all people, including the Taiwanese, who have struggled to gain an excellent health care system. However, what is now required is access to the highest standard of health information and services to maintain their status and also to improve the standards of others in the global family. It is clear in the WHO Constitution that what is essential for ensuring interrelationship, or for entering into relations with WHO or benefiting from its assistance and attending its meetings, is not statehood but compliance with the Organization's observations or objectives and, of course, contributing to its achievements and responsibilities. Therefore, any refusal based on the concept of statehood is totally irrelevant here. Similarly, it is also totally irrelevant to argue that permitting the participation of Taiwan in the work of the Organization could set a precedent. Such an argument does not correspond to reality. Looking around this very hall, we note the presence of a number of observers who have been invited on a permanent basis to the Health Assembly, some of them not claiming statehood. These observers are particularly significant and constitute already-set precedents. Therefore, to argue that the invitation of Taiwan would contradict the practice of this Health Assembly is contrary to reality. None – I repeat, none – of the arguments against the participation of Taiwan as observer can thus be maintained. On the contrary, Taiwan is as fully qualified to participate in the Health Assembly as observers present in this hall here with us. In conclusion, it is evident from Taiwan's achievements on matters related to health that its participation as observer would greatly benefit all Members of WHO and could enhance the achievement of global health and security. The Government of the Republic of the Gambia therefore is convinced that the Health Assembly should include this item. Our firm belief and conviction is that sooner or later we cannot refuse to discuss this item. Let us include them – or let us include this item in our agenda – preferably now rather than later.

The PRESIDENT:

Bearing in mind that we have a tremendously heavy agenda today, I request delegates to be as short and sweet as possible. Twenty-eight speakers have already spoken on this and everybody who was involved knows exactly what happened. I would therefore like to ask delegates to be short, so that we can resolve this matter.

El Dr. BALAGUER (Cuba):

Señor Presidente, Cuba rechaza categóricamente la inclusión del punto relativo a Taiwán en el orden del día de la Asamblea Mundial de la Salud, porque sería una flagrante violación de las decisiones de la Asamblea General de las Naciones Unidas y de este propio órgano de la OMS. Además, sería una acción contraria a la Constitución y las reglas de procedimiento de esta Organización.

La Organización Mundial de la Salud es un organismo especializado de las Naciones Unidas, integrada por Estados soberanos. De acuerdo con la resolución 2758 (XXVI) de la Asamblea General de las Naciones Unidas, la resolución WHA25.1 de la Asamblea Mundial de la Salud, así como de su Reglamento Interior y de la Constitución de la OMS, Taiwán, como provincia de China, no califica para convertirse en Miembro o Miembro Asociado de la OMS, ni para participar en esta ilustre Asamblea como observador.

Existe una sola China en el mundo, y Taiwán es parte inalienable de ella. El Gobierno chino es el único gobierno legítimo que representa a todo el pueblo chino; así ha sido universalmente reconocido por la comunidad internacional, incluidas las Naciones Unidas. En consecuencia, la propuesta que hoy se quiere proponer con Taiwán es una grave violación de las resoluciones antes mencionadas, así como de la Constitución y las reglas de procedimiento de esta Organización.

Señor Presidente: resulta ofensivo tratar de forzar a todos los aquí presentes y en cualquier foro de esta Organización a que actúen al margen del derecho internacional, desconociendo las referidas decisiones adoptadas en el marco de las Naciones Unidas y la OMS. Quienes pretenden transgredir la ley internacional sólo pueden recibir a cambio el rechazo enérgico de todos los Estados que, como Cuba, somos fervientes defensores del derecho internacional.

La Organización Mundial de la Salud debe centrarse en continuar consolidando las acciones que desarrolla para mejorar la salud de todos los habitantes del planeta, en vez de enrolarse en una maniobra política que la aleja de sus objetivos. El respeto a la soberanía de los Estados y su integridad territorial es uno de los principios fundamentales consagrados en la Carta de las Naciones Unidas, que guía desde hace más de 50 años las relaciones internacionales entre los Estados.

Para Cuba, son claros los propósitos que se persiguen tratando de forzar el tratamiento del tema relacionado con Taiwán en las sesiones de esta 57ª Asamblea Mundial de la Salud: concederle un estatus internacional a Taiwán que no le corresponde, porque ese territorio es una provincia de China y, como tal, a sus autoridades no pueden concedérsele derechos que sólo le pertenecen al Gobierno de la República Popular China.

Señor Presidente: hemos escuchado la explicación del delegado de China sobre las medidas que se han venido adoptando para propiciar una mayor interrelación entre la OMS y Taiwán, así como de los ejemplos que ilustran las amplias posibilidades brindadas para que los habitantes de Taiwán reciban las atenciones médicas necesarias para atender los problemas de salud que se han visto obligados a enfrentar. Tal es el caso, por ejemplo, de las medidas adoptadas por el Gobierno de China en relación con la situación del SRAS, el cáncer y otras enfermedades en Taiwán. Estas informaciones descalifican cualquier intento de esgrimir presuntas preocupaciones de carácter sanitario para justificar la consumación de objetivos políticos.

No debemos dedicarle mucho tiempo a este asunto. Importantes debates y decisiones tenemos por delante en los escasos seis días de las sesiones de la Asamblea Mundial de la Salud. No dejemos que maniobras políticas obstruyan esas deliberaciones. Millones de personas en el mundo esperan propuestas y acciones concretas de la OMS y ellos no nos perdonarían que, nosotros, sus representante, asumiendo decisiones ilegítimas, dañemos la capacidad y efectividad de esta Organización para encontrar soluciones concretas a sus problemas.

Por todo esto, señor Presidente, reitero que Cuba se opone enérgicamente a que se incluya en el orden del día de la Asamblea Mundial de la Salud este punto sobre la invitación a las autoridades de Taiwán en calidad de observadores, y por eso apoya el dictamen que presentó el Presidente. Muchas gracias.

Mr UNA (Solomon Islands):

This is a long-standing issue. This world includes Taiwan and its 23 million people, and to exclude them from participating in the World Health Organization and Health Assembly is morally wrong.

I believe that it is morally right and very important to all we Member States to carefully consider the request by Taiwan to be admitted as an observer to the World Health Organization and the Health Assembly and we should not be unduly pressurized by mainland China – or the People's Republic of China – to block the participation of Taiwan. Damage control is best achieved by allowing justice and common sense to prevail – not by blocking it – and this issue will continue. It would be in everybody's best interest, and would benefit all of us – and especially the 23 million people of Taiwan – if Taiwan were accepted as an observer to WHO and the Fifty-seventh World Health Assembly. On this premise, the Solomon Islands Government appeals to this Health Assembly to grant Taiwan the status of observer to WHO and the Fifty-seventh World Health Assembly under the provisions of the WHO Constitution.

El Dr. LÓPEZ BALDIZÓN (Nicaragua):

La delegación de mi país apoya la moción de Gambia para que le República de Taiwán pueda participar como observador en las sesiones de la Asamblea Mundial de la Salud, la cual no solamente es necesaria, sino que también está justificada en el documento de Constitución de la Organización Mundial de la Salud, en su Artículo 8, en el documento firmado en 1946. Así lo establece también el artículo 47 del Reglamento Interior de esta Asamblea Mundial de la Salud.

La República de Taiwán participa en Centroamérica como Miembro Observador del Sistema de Integración Centroamericana y también como Miembro Observador del Parlamento Centroamericano. Por eso consideramos que con el nivel de desarrollo económico, social, político y de salud alcanzado por la República de Taiwán y demostrado en el adecuado y correcto manejo sanitario de la reciente epidemia del síndrome agudo respiratorio queda totalmente facultado para poder aportar y recibir también el aporte y la asistencia técnica de la Organización Mundial de la Salud.

El lema anterior de Salud para Todos en el año 2000 quedaría incompleto si excluimos países, Estados o territorios o pueblos enteros, que quedarían en un proceso de exclusión social y sanitario, aumentando la iniquidad en el mundo. Consideramos que para poder avanzar en estos lemas de Salud para Todos es necesario que todos, sin excepción, sin exclusión, estén incorporados a los beneficios y privilegios de las políticas sanitarias que adecuadamente ha manejado durante tantos años la Organización Mundial de la Salud.

En consecuencia, Nicaragua respalda la moción de Gambia para que Taiwán se incorpore como observador a esta Asamblea Mundial de la Salud.

Mr GAO Qiang (China):

高强（中国）:

主席先生:

首先，感谢您给我发言的机会。中国代表团热烈祝贺您就任本届大会主席，相信本届大会在您的卓越领导下，一定会富有成效地圆满完成各项工作任务。

主席先生、各位部长、各位代表，

在过去七年的世界卫生大会上，台湾当局无视《联合国宪章》和世界卫生组织的宗旨、原则和法律规定，违背世界卫生大会连续做出的决定和绝大多数坚持正义国家的共同意愿。一意孤行，唆使和蒙骗少数国家提出所谓“邀请台湾以观察员身份参加世界卫生大会”的提案，连续七年遭到了失败。在今天上午举行的总务委员会上，少数成员国再此提出这个早在 20 世纪 70 年代初就已解决了的政治和法律问题。他们提出这个不应由世界卫生大会审议和决定的问题，其真实目的是制造“两个中国”或“一中一台”，实现分裂中国的政治图谋。在此，我严正地指出，邀请台湾参与世界卫生组织于法不符，于理不容。总务委员会关于不将涉台提案列入世界卫生大会临时议程的建议是完全正确的。借此机会，我代表中国政府阐述以下立场和看法:

一、台湾没有资格以任何形式加入世界卫生组织

世界卫生组织是联合国专门机构之一，只有主权国家才能参加。联大第 2758 号决议和世界卫生大会 WHA25.1 号决议早已清楚地确认，中华人民共和国政府的代表是中国在联合国和世界卫生组织等所有联合国机构中的唯一合法代表。少数国家提议邀请台湾以观察员身份参加世界卫生大会没有任何法律依据。请大家注意看一看世界卫生大会议事规则第三条的规定，总干事可以邀请已提出会籍申请的国家、已代为申请为准会员的领地、以及虽经签署但尚未接受组织法的国家，派观察员出席卫生大会的会议。这里讲总干事邀请作为观察员有三个条件，其中两个是国家一个是领地。台湾符合哪一条？在目前以观察员身份参加世界卫生大会的有梵蒂冈、马耳他骑士团、巴勒斯坦、国际红十字会、国际红十字和红新月会。他们之中有的是主权国家，有的为国际法所确认，有的是国际性非政府组织。而台湾作为中国领土的一部分，根本不符合上述任何一种情况。它有什么资格以观察员身份参加世界卫生大会呢?

尊重国家主权和领土完整、反对外来干涉是《联合国宪章》所倡导的处理国家关系的基本原则。世界上只有一个中国，大陆和台湾同属中国。这是中国与各国以及国际组织交流与合作的基础，也是绝大多数国际社会成员的共识。台湾问题是中国的内部事务，应由海峡两岸的中国人民自己解决。任何外国不管它是大国还是小国，是穷国还是富国，都不能插手或干涉中国的主权和内政。少数国家提出涉台提案，目的不是为了台湾地区的民众健康，而是挑战一个中国的原则，破坏中国主权和领土完整。企图将中国内政问题国际化。这是严重违背《联合国宪章》宗旨和原则的行为。这种做法也严重干扰了世界卫生大会的工作，造成会员国之间的政治对抗和资源浪费。作为联合国成员国，所有国家都应该遵守联合国宪章和联大决议。作为世界卫生组织会员国，所有国家都应遵守世界卫生组织《组织法》和世界卫生大会决议。有人想借世界卫生组织的舞台分裂中国，制造“两个中国”和“一中一台”，中国政府和中国人民将坚决反对。

近年来，台湾当局不甘心连续七年的失败，不断变换手法，妄图欺骗会员国，达到混入世界卫生组织的目的。只要我们认真读一读世界卫生组织《组织法》和其它法律文件，就可以清楚地认识到台湾作为中国的一部分，不管如何变换名称，都不能够参加世界卫生组织。

二、台湾与中国大陆和世界卫生组织的卫生技术交往不存在任何困难

少数国家提出“台湾地区不参加世界卫生组织就得不到世界卫生组织的技术支援”，这是谎言。长期以来，中国大陆与台湾地区卫生界交往密切，在医药卫生、医学教育和医院管理等领域，长期保持着广泛的合作。去年春夏之交，突如其来的 SARS 疫情袭击了中国大陆的部分省份和台湾地区。为携手抗击 SARS，中国大陆卫生专家通过视讯方式与台湾同行召开了多次 SARS 防治专业座谈会。就 SARS 的诊断标准、医疗方案、预防措施等进行了交流。2003 年虽然有 SARS 影响，中国大陆仍然有 1,191 名卫生人员赴台交流。去年 12 月，中国大陆举办了“海峡两岸中西医结合的防治 SARS 学术研讨会”，台湾的中医药专家参加了会议。今年第一季度，中国大陆卫生领域共有 243 人次赴台。今年 4 月香港主持召开了“传染病防治研讨会”，海峡两岸及港澳地区共有 46 名代表参加，其中包括台湾医学界有影响的专家教授。海峡两岸医疗同道为增进两岸同胞的健康福祉，建立了民间渠道的经常联系。去年以来，台湾医疗卫生专家先后访问过中国疾病预防控制中心和北京市、广东省的医疗科研机构。今年 4 月 22 日，北京、安徽发现 SARS 病例的当天，我们就通报了台湾地区，目前仍坚持每天向台湾有关方面通报医疗情况。

在中央政府的同意和安排下，世界卫生组织与台湾开展了技术交流。2003 年 5 月，世界卫生组织专家赴台考察 SARS 疫情，台湾专家参加世界卫生组织 SARS 流行病会议，6 月出席国际 SARS 大会。今年 1 月，世界卫生组织专家再次赴台考察疫情。还有许多台湾医疗卫生专家作为世界卫生组织有正式关系的非政府组织代表，出席世界卫生组织有关专业会议。对台湾专家学者参加多种形式的国际卫生技术交流，我们历来表示欢迎和支持。

三、积极促进台湾地区同世界卫生组织开展技术交流合作

中国大陆和台湾同属中国，两岸同胞骨肉相连，中国中央政府一向关心两岸人民的健康福祉。我们反对台湾以观察员名义参加世界卫生大会，是反对台湾当局把健康问题政治化，借机搞“两个中国”和“一中一台”。对台湾地区人民同世界卫生组织开展技术交流，中国中央政府将采取更加积极的态度。在此，我代表中国政府郑重表示：

第一，诚挚的欢迎台湾派医疗卫生专家参加中国代表团出席世界卫生大会。

第二，在一个中国的原则下，中央政府愿意开展两岸的商谈，共同研究台湾地区以适当方式参加世界卫生组织有关技术活动问题。

สมบัติห้องสมุดรัฐสภา

第三，在两岸协商达成一致之前，作为一项特殊安排，中央政府愿意同世界卫生组织秘书处积极协商，推动并帮助台湾医疗卫生专家参与世界卫生组织的技术交流活动。

第四，台湾地区如需要世界卫生组织提供技术支持，只要向中央政府提出，我们都会给予积极支持。

主席先生：

过去七年中，少数国家连续抛出涉台提案，连续遭到世界卫生大会和总务委员会的拒绝。事实证明，涉台提案无论以何种面目出现，最终都难逃失败的结局。今年大会议题多、任务重。中国代表团同大多数国家一样，不希望本届卫生大会原定的议程受到涉台提案的干扰。我坚信，在座的绝大多数国家代表都会主持正义，支持中国代表团的立场，捍卫联大和世界卫生大会有关决议和尊严的法律效力。拥护总务委员会的建议，反对将涉台提案列入世界卫生大会临时议程。同时我们也希望，这种没有意义、不得人心的提案今后不要再出现在世界卫生大会的庄严讲台上。

谢谢主席先生。

The PRESIDENT:

I would like to say to the Health Assembly that we have a tremendously heavy agenda of health-related matters. I therefore request the delegates to be very short so that we can go forward with our very important agenda: please try to keep to your point and the point will be taken.

M. BOUKOUBI (Gabon) :

Monsieur le Président, permettez-moi tout d'abord de joindre ma voix à celles de ceux qui m'ont précédé pour vous exprimer nos félicitations à la suite de votre brillante élection et de celle de tous vos collègues du Bureau ; je pense particulièrement à Mme le Dr Tshabalala-Msimang qui représente la Région africaine de l'Organisation mondiale de la Santé.

Monsieur le Président, je partage votre avis, à savoir que nous avons un ordre du jour très chargé et qu'en conséquence il vaut mieux aller très vite à l'essentiel. J'admire l'endurance de nos collègues qui, depuis plusieurs années, n'arrêtent pas de relancer le débat autour de l'inscription de Taïwan pour participer à l'Assemblée mondiale de la Santé, fût-ce-t-il comme observateur. Cependant, les mêmes causes produisant les mêmes effets, je crains que, encore une fois, si nous nous éternisons sur cette question, nous ne perdions beaucoup de temps pour arriver au même résultat. En effet, il se trouve que comme l'ont dit ceux qui m'ont précédé, l'OMS est une institution spécialisée des Nations Unies. De ce fait, elle obéit aux règles des Nations Unies, de ce fait, elle applique les décisions de l'Assemblée générale des Nations Unies. Il se trouve que jusqu'à présent, autant que nous sachions, la question de la présence de Taïwan dans ces différents organismes n'a pas trouvé de solution. En conséquence, nous pensons qu'il vaut mieux que nous nous consacrions à la multitude des problèmes que nous avons à traiter. Il se trouve qu'ici, c'est l'Assemblée de la Santé qui est appelée à se pencher sur les grands problèmes de santé. Il conviendrait donc que nous nous penchions sur les problèmes de santé et que nous renvoyions les questions d'ordre institutionnel, d'ordre politique aux instances compétentes. Je souscris donc à la proposition du Bureau de ne pas inscrire Taïwan ou l'examen de la question de Taïwan en tant qu'observateur à l'Assemblée de la Santé. Je vous remercie.

El Sr. ZAPATA (Honduras):

Señor Presidente: usted preguntaba al inicio si había conformidad con la decisión tomada en la Mesa de la Asamblea. Mi respuesta es no, lógicamente, tal como le dije durante la reunión de la Mesa. Explicar nuestro apoyo a favor de Taiwán es muy sencillo: somos solidarios con el pueblo y el Gobierno de Taiwán. Son nuestros amigos. Asimismo, encontramos injustificable que no se les permita la participación como observadores. Veintitrés millones de personas merecen un acceso directo y sin restricciones a la información más actualizada para el control de enfermedades. Asimismo, necesitan suministros, medicinas y asistencia técnica directa.

Esta Asamblea y la Organización Mundial de la Salud tienen como responsabilidad primordial la de cuidar la salud de todas las personas; 23 millones de taiwaneses no están recibiendo esa atención. Es hora de que eso cambie. Hay precedentes para ello, y la Constitución de la OMS misma lo contempla.

M. OULD MOHAMED LEMINE (Mauritanie) :

Je me joins aux autres orateurs pour féliciter le Président ainsi que les membres du Bureau pour leur élection au présidium de cette Assemblée.

Monsieur le Président, je pense que le débat que nous sommes en train d'avoir ici maintenant est un débat qui a été clos en 1971 lorsque l'Assemblée générale des Nations Unies par sa résolution 27/58 a décidé de restaurer la République populaire de Chine dans tous ses droits et a reconnu le Gouvernement chinois comme le représentant légitime unique du peuple chinois. Mon pays qui avait coparrainé cette résolution, comme je l'avais rappelé tout à l'heure au Bureau, est surpris de voir cette question soulevée encore ici, plus de 30 ans donc après qu'elle ait été réglée définitivement par l'Assemblée générale des Nations Unies. C'est cette même décision que l'Assemblée mondiale de la Santé, cet auguste organe réuni aujourd'hui, a entériné mot pour mot quasiment une année plus tard. C'est pourquoi nous estimons qu'il n'y a pas de raison de revenir sur ce débat et que le fait d'y revenir détourne cette Assemblée de son ordre du jour extrêmement important en lui imposant une discussion sur une question qui a été réglée il y a 30 ans. Taïwan est une province de la Chine au regard du droit international, au regard de la Constitution de l'OMS, de son Règlement intérieur et en partie de la résolution pertinente WHA25.1 prise par cette Assemblée en 1972. Taïwan est une province de 20 et quelques millions d'habitants, mais c'est une province qui appartient à une très vieille et très ancienne grande nation de plus de 1 milliard d'êtres humains. Taïwan ne peut pas prétendre à un statut propre à l'OMS ni comme observateur ni comme Membre associé, encore moins comme Membre à part entière.

Cela dit, le Gouvernement chinois a toujours pris soin de la santé et du bien être de la population de Taïwan, comme vient de nous le rappeler le chef de la délégation chinoise qui a également présenté un certain nombre de propositions concrètes, y compris la possibilité d'inclure des professionnels de santé de Taïwan dans la délégation chinoise ; et le Secrétariat nous l'a toujours rappelé, Taïwan bénéficie déjà d'un accès total à la banque de données de l'OMS et plusieurs experts de l'Organisation s'y sont rendus et y ont entrepris des investigations, en particulier sur le syndrome respiratoire aigu sévère.

Compte tenu donc de tous ces éléments, mon pays estime qu'il n'est pas indiqué d'inscrire cette question à l'ordre du jour de l'Assemblée de la Santé de l'OMS, qu'il s'agit en fait d'une façon déguisée de reprendre ou de consacrer la théorie de deux Chine ou d'une Chine d'un côté et de Taïwan de l'autre, que cette tentative est contraire à la Charte des Nations Unies, à la Constitution de l'OMS et aux résolutions adoptées par les organes compétents des Nations Unies, en particulier l'Assemblée générale des Nations Unies et l'Assemblée de la Santé de l'OMS.

Pour toutes ces raisons, nous souscrivons pleinement à la recommandation faite par le Bureau et nous nous opposerons à la proposition d'inscrire cette question à l'ordre du jour. Merci.

Ms DOUGLAS (Saint Kitts and Nevis):

My message is short. I speak on behalf of the Government and people of the Federation of Saint Kitts and Nevis for the full participation of Taiwan in this World Health Assembly as an observer. I support the Republic of the Gambia's view with regard to Taiwan.

Dr AL-NA'AMI (Yemen):

الدكتور محمد النعمي (اليمن):

سيدي الرئيس، إننا نرى عدم الإطالة في هذا الموضوع كونه لا يستند إلى أي قاعدة قانونية، فالقرار رقم ٢٧٥٨ للجمعية العامة للأمم المتحدة وكذلك قرار جمعية الصحة جص ع٢٥-١ ، قد حسما قضية حق التمكين للصين في الأمم المتحدة ومؤسساتها المتخصصة، بما فيها منظمة الصحة العالمية بشكل عادل وكامل وشاملٍ من الجوانب السياسية والقانونية والإجرائية. ومازال القراران يتمتعان بالفعالية القانونية حتى الآن، وطبقاً للنصوص المعنية في ميثاق منظمة الصحة العالمية وكذلك القواعد الإجرائية لجمعية الصحة العالمية، فإن تايوان باعتبارها مقاطعة للصين ليس لها أهلية في الانضمام إلى منظمة الصحة العالمية بصفة مراقب. وعليه نرى عدم التكرار في مثل هذا وتشويش سير أعمال جمعية الصحة العالمية. وقد رفض المشروع على مدى السنوات السبع السابقة ولا داعي لتكرار مثل هذا النقاش غير المُجدي.

شكراً لكم سيدي الرئيس.

Professor BOUPHA (Lao People's Democratic Republic):

As we have a heavy agenda, in order to avoid unnecessary discussion and delay, our position related to the representation of Taiwan as an observer at the Health Assembly is well known and remains unchanged. For us and for the majority of Member States, there is only one China in the world. The Government of the People's Republic of China is the sole legal government representing the whole of China, and Taiwan is only one inseparable part of China. Therefore, our delegation supports the point of view of the People's Republic of China and Cuba and opposes both the acceptance of Taiwan as an observer and the inclusion of this problem as an agenda item for the Fifty-seventh World Health Assembly.

Mrs FERNANDO (Sri Lanka):

I recall a little while ago in the General Committee that some 31 countries spoke against this proposal to include Taiwan as an observer at the Health Assembly. They stated that this has no legal basis. We therefore fully support the recommendation of the General Committee that it should not be included on the agenda. I recall at that time that this was a unanimous decision.

Mrs BAROUD (Chad):

Our Health Assembly must now make a decision regarding the inclusion on its agenda of a supplementary item concerning Taiwan. The General Committee has recommended that the Health Assembly disagree with this request. My delegation is in total disagreement with this recommendation and I will explain why, in its opinion, the supplementary item must be included. Before doing so, however, allow me to place the discussion in its proper perspective. At this stage we are not requested to decide if an invitation has to be sent to Taiwan, but have only to decide if the question of Taiwan's participation as an observer is an issue worth discussing, without prejudice to the final outcome. In this respect, it is astounding to note that very few – indeed virtually none – of the statements at the General Committee opposing the inclusion of the item made reference to health considerations. Political, legal or constitutional considerations have been used instead of focusing on the main factor of health which, for an organization whose objective is the attainment by all peoples of the highest possible level of health, should be a high priority if not the priority.

Indeed, in the opinion of my Government the question of the presence of Taiwan at this Health Assembly, from a health point of view, is worth considering for a number of valid reasons. Firstly, there are technical reasons justifying the inclusion of the item on the agenda, and the reasons are as follows. As a matter of principle, my Government considers it contrary to the objectives of the Organization, the aim of which is to protect the health of the world, to refuse to discuss openly the health situation of a population of 23 million people. Moreover, from a health point of view, all Members of this Organization know that a severe infectious disease, SARS, emerged in Asia a year ago. The Health Assembly itself recognized in a resolution that this disease poses a serious threat to global security, the livelihood of populations, the functioning of health systems and the stability and growth of economies. SARS affected 29 countries with around 8096 cases and 774 deaths, including that of a member of WHO staff. Everybody knows that some of these cases occurred in Taiwan. Actually, Taiwan accounted for 9.43% of the global deaths resulting from this new infectious disease. Could we reasonably consider that it is not worth discussing this outbreak with one of the countries suffering from the disease? Late last year another disease, avian influenza, re-emerged in the same region. This underscored the danger that the absence of contact with Taiwan could create. Can we continue to ignore reality?

The current attitude towards Taiwan represents a potential danger for each country in the world. We believe that the refusal to consider the question of the participation of Taiwan creates a risk, directly or indirectly, immediately or eventually, for each Member of our Organization. WHO must remain informed and must obtain and disseminate relevant information and data to monitor, prevent and respond to all conceivable outbreaks of infectious disease. The health administration of Taiwan is the sole legal body which possesses relevant information on any outbreak of disease that could occur on that island and potentially threaten global health, and which is able to take the necessary measures to combat and prevent certain diseases. In addition to its 23 million people, Taiwan's health administration has to deal each year with health matters relating to 27 million international air passengers, 225 000 international flights, 51 000 seagoing vessels and hundreds of millions of tons of international cargo. The Member State that claims to represent Taiwan in the Organization and this Health Assembly has neither the authorization from the people of Taiwan nor the jurisdiction or control over any health matters relating to Taiwan. The claimant cannot even compile health data about Taiwan in its report to the Organization.

The Health Assembly has to realize that without any status in WHO, Taiwan is not obliged to be involved in the Global Outbreak Alert and Response Network, and Taiwan's voluntary efforts in this regard have not been well received. For the Organization, the inclusion of the item regarding Taiwan's participation in the Health Assembly should be a matter of practical need and health imperatives. It is unfair, impractical and even dangerous to expect that Taiwan can function effectively in enforcing relevant international health resolutions, regulations and conventions when it lacks adequate access to participate in the work of the Organization. If the Health Assembly really prefers to maintain this position and to take the risk of not being informed of an outbreak of a lethal disease in Taiwan, this is a very serious matter. In the opinion of my Government, the refusal to open a discussion on this problem impinges on the Organization's ability to ensure the health of the populations of all its Member States.

There is an additional reason in favour of the inclusion of the supplementary item. Taiwan has an excellent record regarding the eradication of, and immunization against, some infectious diseases, as well as recognized expertise in the field of medical research. Is it reasonable to continue not to make use of the scientific knowledge offered by Taiwan? Without any doubt, Taiwan could share its experience and resources with the rest of the world, as it does at present with a number of countries.

The arguments against the inclusion of the item are in no way convincing. At this stage, I do not wish to enter into a legal and political discussion, but I would like to reaffirm that the inclusion of such an item, contrary to what was argued, will in no way disregard the provisions of the Constitution and will be fully consistent with practice followed by the Organization. In no way, I insist, will this item constitute a statement regarding Taiwan's political status. There are a number of articles in the fundamental text that permit participation in WHO activities. This might be called functional participation as it does not involve any question of membership. The same is the case for a number of other organizations. But besides this example there is also the recognized practice of regularly inviting

a number of observers – at present five – to attend our Health Assembly. Recognizing this unchallengeable precedent, is it not justified for us to accept to list the question among those to be discussed? Such a decision would not be exceptional in international forums. A number of multilateral intergovernmental institutions and mechanisms such as the World Trade Organization have accepted Taiwan's participation. Other examples are provided by the Asia-Pacific Economic Cooperation, or in recent years the Regional Fisheries Management Organisation, which recognized the need for all significant fishing entities such as Taiwan to participate in the multilateral conservation of fish stocks. Accordingly, to discuss such a question in our Health Assembly will be fully in line with the attitude adopted by many other international mechanisms.

The Organization is conducting extensive consultations in view of the revision of the present International Health Regulations. It has underlined in the draft that the emergence of new diseases and the resurgence of old ones as issues of international public health concern have made clear the need to broaden the applicability of the Regulations. It is obvious that this objective cannot be achieved in the absence of Taiwan, particularly in light of the recent outbreaks in Asia. It is also more than evident that only Taiwan possesses the ability to properly implement the measures prescribed. To conclude, in the opinion of my Government the inclusion of this item will permit a fair debate on a matter which directly concerns the interests of the Organization and its Members. It would be in total conformity with the noble objectives of our Organization. And how could public opinion understand that the World Health Organization, in the present epidemiological context, refused to discuss openly a health problem of vital importance? There is no choice. We have to add this item to our agenda, and we request a consultation – a roll-call vote – on the issue.

The PRESIDENT:

Thank you, Chad, for giving us two very good speeches in two hours. Right now we have 24 speakers and if this goes on, I think, 27 countries to speak. And I think that if the time is taken like this, we will not reach even one quarter of our agenda. I request delegates, again, to be as short as possible.

Ms HUNT (Belize):

Belize fully supports Gambia's proposal to include in the agenda the request of Taiwan to be given observer status at the Fifty-seventh World Health Assembly. The Constitution of the World Health Organization specifically states that the health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states. The Constitution further states that the achievement of any State in the promotion and protection of health is of value to all. Every year since the establishment of WHO, Member States have met to review the world health situation, to share experiences and developments in health, to discuss health topics of international interest, to forge binational and multinational alliances in health, to promote the development and implementation of regional and subregional health projects, and the list goes on and on. The experience of the SARS epidemic of 2003 has taught us that, more and more, the effort to control diseases transcends borders and requires the concerted efforts of all countries affected. WHO and the Health Assembly create a unique opportunity for all people of the world to benefit from the collective knowledge accumulated to date in the fight against diseases and the promotion of health. Small and large nations, rich and poor, all dine at the table of knowledge and benefit from the experience of others. The Belize delegation and the Government it represents is of the opinion that no individual or group of people should be excluded from this benefit. We believe that all members of the human race should have access to this international forum and be informed of decisions and resolutions that affect their health. We believe that all peoples should have the opportunity to share their gains and experiences in health and to partake in the global effort to improve the health of the people of the world. The 23 million people of Taiwan, as citizens of the world, have equal rights to the benefits and opportunities that WHO and the forum of the Health Assembly provide.

Mr ZIMJANIN (Russian Federation):
Г-н ЗИМЯНИН (Российская Федерация):

Благодарю Вас, г-н Председатель.

Примите поздравления делегации Российской Федерации в связи с назначением Вас на столь высокий пост.

Следуя Вашему призыву, буду предельно краток. Позиция Российской Федерации заключается в том, что мы неизменно подтверждаем, что правительство Китайской Народной Республики является единственным законным правительством Китая, а Тайвань – неотъемлемой частью Китайской Народной Республики. Разделяя неприятие Китайской Народной Республикой концепции "двух Китаев" – "одного Китая, одного Тайваня", – Россия не поддерживает участие Тайваня в Организации Объединенных Наций и в других международных организациях.

Благодарю Вас, г-н Председатель.

Dr CHITUWO (Zambia):

My delegation asked for the floor to comment on the issue of Taiwan's application for observer status. It is true that Taiwan has a population of 23 million, they are technically advanced and are powerful, but we would like to observe that following previous resolutions of the United Nations, this is not procedurally correct and is not legally right. We understand that in terms of health, mainland China has always extended her hand to assist her brothers and sisters in Taiwan. To seek observer status or any other status on account of financial or any other strength would be a recipe for any other province in our sovereign states to stand up one day and say, "Look, I have all these, why shouldn't I have observer status at the Health Assembly?". That would be a recipe for anarchy. Our argument therefore is that we believe and support the "one China" principle. This is the legal standing and we urge all other sovereign states to support this principle and therefore reject the application by the Taiwan authorities for observer status at the Health Assembly.

Mr MYA THAN (Myanmar):

Myanmar has consistently practised the "one China" policy. We cannot accept any move or initiative that will run counter to this principle stand of Myanmar. The proposal inviting Taiwan to participate in the Health Assembly as an observer is not a health-related issue, it is in fact a political issue. The delegation of Myanmar wishes to make it absolutely clear that we reject any attempt to use the pretext of combating SARS or any other disease-control issues as a ploy to advance the cause of seeking an observer status for Taiwan at the Health Assembly. In this regard, the delegation of Myanmar categorically opposes the proposal for inviting Taiwan to participate in the Health Assembly as an observer. We fully support the recommendation of the General Committee not to include this on the agenda of the Fifty-seventh World Health Assembly.

Mr JANG Il Hun (Democratic People's Republic of Korea):

My delegation fully supports the "one China" principle. The overwhelming majority of countries around the world recognize "one China" as embodied in the United Nations and its specialized agencies. Therefore, inclusion of Taiwan's participation as an observer on the agenda of the Health Assembly is a grave violation of the sovereignty and territorial integrity of the People's Republic of China, of which Taiwan is a part. This does not mean any denial of health benefits for the Taiwanese people; they can have technical exchanges in cooperation with the World Health Organization, in accordance with the measures taken by the central Government of China. Further discussion of this issue does not help the smooth operation of the Health Assembly, so my delegation once again states its strong objection to the inclusion of the Taiwan-related proposal on the Health Assembly agenda, as recommended by the General Committee this morning.

El Sr. GUZMÁN VALENCIA (Colombia):

Señor Presidente: al igual que las delegaciones que nos han precedido, hago propicia esta oportunidad para hacer llegar, en nombre de la delegación de Colombia, la felicitación por su elección, así como a los demás miembros de la Mesa. Nuestra delegación desea manifestar su apoyo a la moción presentada por la delegación de China y, en consecuencia, acoge la recomendación de la Mesa en el sentido de no incluir en el orden del día la discusión sobre la inclusión de Taiwán como observador.

Sra. ROMÁN MALDONADO (República Dominicana):

Señor Presidente: el SRAS en el 2003 mostró a la comunidad internacional la necesidad de incluir a Taiwán en el sistema de respuesta de la OMS. Por ello, la República Dominicana apoya que Taiwán participe en la OMS como observador. El pueblo taiwanés pide, por ejemplo, poder acceder directamente a las informaciones actualizadas sobre el control de enfermedades, al mecanismo sistematizado de la OMS para distribución de vacunas, a las referencias estandarizadas para exámenes de laboratorio, como algunos de los ejemplos que podríamos citar. La comunidad internacional se beneficiaría igualmente de las experiencias sanitarias de Taiwán.

La República Dominicana está convencida de que se debe encontrar un mecanismo para dar respuesta a las necesidades sanitarias del pueblo de Taiwán. El carácter de observador sería una vía idónea para ello. Además, se estaría en armonía con la deontología profesional de salud y de la Organización que la comunidad internacional ha creado para apoyar las aspiraciones de la humanidad de disfrutar de un mejor nivel de salud.

Professor HOMIEDA (Sudan):

The delegation of Sudan shares the disappointment of many other delegations that the issue of Taiwan surfaced on the agenda of the Health Assembly despite previous resolutions of the United Nations bodies which relegated the issue. Previous resolutions enjoyed wider support for a "one China" policy, offering it the legitimacy of full representation of its entire territories, including Taiwan. China continued on this basis, assuming its State's responsibility in the health sector by extending support of services to Taiwan, most recently during the outbreak of SARS, a period which saw increased international cooperation between WHO and China and paved the way for the delivery of medical supplies and technical services to mainland China and Taiwan as well. Sudan believes that tabling this issue on the agenda of the Health Assembly undermines the decision of the United Nations supreme bodies and challenges their credibility. Therefore my delegation supports the discontinuation of the issue from any further discussion.

Dr PARIRENYATWA (Zimbabwe):

Zimbabwe has made itself very clear on many occasions before, both in this forum and elsewhere. There is only one China in the world: no other entity should be permitted to represent the gallant people of China. My delegation rejects totally any attempt to elevate Taiwan to a new status. We have already spent half a day on this issue. My delegation therefore requests that we waste no more time on this political issue. We should quickly resolve not to revisit this issue in this forum in the future. The Chinese people are adequately and appropriately represented by the delegation of the People's Republic of China.

Mrs SUDARAT KEYURAPHAN (Thailand):

Thailand recognizes that the right to good health should be provided to all people but thinks that this right should be exercised within the framework of the overriding principle of non-interference in internal affairs of Member States. As a Member State of WHO, Thailand respects the ruling of the General Committee not to include the proposal to invite Taiwan to participate in the Health Assembly

as an observer. This matter has already been rejected in the General Committee and we should not repeat the work that has already been agreed in the Committee. Thailand upholds the accepted principles of "one China" policies and agrees that the decisions were made on a sound legal basis. Thailand wishes to encourage cooperation on health matters to make cross-straits progress through using channels provided by the Government of the People's Republic of China. Therefore, the agenda should not include such proposals for observer status in the Health Assembly.

Dr SLATER (Saint Vincent and the Grenadines):

I wish to be very brief in order to avoid unnecessary repetition. Saint Vincent and the Grenadines fully endorses the sentiments of the nations that have supported the inclusion of Taiwan as an observer. I wish to quote you, Mr President. Just a while ago you said that "nothing can be politically right that is morally wrong". I think the inclusion of Taiwan as an observer is morally correct: you may decide whether it is politically wrong.

I therefore propose that this issue be included on the agenda and be put to a vote eventually during this Fifty-seventh World Health Assembly plenary.

Dr SELUKA (Tuvalu):

Thank you for giving me the opportunity to speak in support of Taiwan's application to be an observer at this Health Assembly. Tuvalu has been receiving substantial aid from Taiwan and therefore a friend in need is a friend indeed. I am sure that some of my friends who have been speaking on behalf of Taiwan have kept this to themselves. Taiwan provides substantial aid of one kind or another to over 70 countries. Seriously, I do not think political and legal considerations are issues in Taiwan's desire to win observer status at the Health Assembly. Taiwan has been playing an important role as an effective provider of humanitarian aid to countries throughout the world and therefore in this role it is fitting that Taiwan's application be seriously considered and endorsed by the Health Assembly.

El Dr. VELÁZQUEZ (Paraguay):

Señor Presidente: en primer lugar quiero felicitarlo por su elección como Presidente de la Asamblea, así como a toda la Mesa.

La delegación del Paraguay lamenta profundamente la recomendación realizada por la Mesa de la Asamblea a la Asamblea de la Salud de no aprobar la solicitud realizada por varios Estados Miembros de la Organización, incluyendo el mío, de incorporar un punto suplementario al orden del día, titulado «Invitación a la República China en Taiwán para participar en la Asamblea Mundial de la Salud».

Tal como hemos expresado durante la reunión de la Mesa de la Asamblea, el estatus actual de Taiwán frente a la Organización Mundial de la Salud la priva, de una manera que no es justa ni sensata, del disfrute pleno y legítimo de los principios superiores que rigen la Organización, que es la obtención del máximo nivel de salud del pueblo taiwanés y del rol activo y eficiente que podría desem-peñar en el marco del sistema integrado de salud mundial, que coadyuvaría de manera significativa a la consecución de los nobles objetivos de la Organización Mundial de la Salud.

La necesidad real e imperativa de Taiwán de involucrarse en las labores de la Asamblea Mundial de la Salud se torna aún más acuciante por el hecho de que el pueblo taiwanés ha sufrido dos recientes brotes del síndrome respiratorio agudo severo y la gripe aviar, que causaron pérdidas humanas y la pérdida de animales de sustento. A ello se suman las dificultades que se plantean a las autoridades sanitarias taiwanesas, el cumplimiento pleno de las resoluciones y convenciones internacionales en materia de salud en el área de Taiwán. Es por ello que mi país apoya firmemente la incorporación de Taiwán a los trabajos de la Asamblea Mundial de la Salud en calidad de observador. Hagamos la salud para todos y por todos. Por último, pido la votación nominal.

Le Dr BIJOU (Haïti) :

Monsieur le Président, comme mes prédécesseurs, je vous félicite pour votre élection et félicite également les membres du Bureau.

Ce matin, les délégués d'Haïti ont soutenu la demande de Taïwan et nous voulons encore une fois confirmer notre position. Les raisons qui justifient cette position sont les suivantes : nous vivons dans un pays où, assez souvent, il y a des conflits politiques et pendant cette période de conflits la position de neutralité de l'Organisation mondiale de la Santé a toujours joué en faveur du peuple. La situation serait beaucoup plus grave si l'Organisation n'intervenait pas en faveur de la santé. Donc pour tout cela nous pensons que, par respect pour l'équité vis-à-vis de ces 23 millions d'habitants qui vivent à Taïwan, admettre Taïwan comme observateur à l'OMS, c'est vraiment respecter l'équité qui est vraiment une valeur principale et fondamentale de l'Organisation. Je vous remercie.

Mr KIRATA (Kiribati):

My Government considers that the time has come now to change the position taken over the last seven years and to confront reality. Since last year, several emerging health problems have appeared in the world, particularly in Asia, which pose – as the Health Assembly itself has recognized – a serious threat to global health security, the livelihood of the population, the functioning of health systems and the stability and growth of economies.

It is clear that efforts to confront emerging health problems at the global level demand the open, honest and full participation of all members of the international community. Taiwan has longed to be recognized as a member of the international community. Inviting Taiwan to participate as an observer in the sessions of the Health Assembly is not only justified but necessary. The WHO Constitution makes use of two different concepts: the "State" and "peoples". The term "State" is used when the provision involves the composition of WHO membership, while the term "peoples" is used in many provisions dealing with substantive issues of participation and activity. Article 1 of the Constitution states, "The objective of the World Health Organization ... shall be the attainment by all peoples of the highest possible level of health.". The emphasis on the concept of "peoples" strongly points to the fact that, to achieve its objective, the World Health Organization must reach all peoples irrespective of state boundaries. Both the WHO Constitution and the International Covenant on Economic, Social and Cultural Rights declare that health is an essential element of human rights and that no signatory shall impede the health right of other peoples. It thus follows that the WHO Constitution openly allows a wide variety of entities, including non-Member States, international organizations, national organizations and nongovernmental organizations to actively participate in the activities of the World Health Organization to reach all peoples.

It is not a question of statehood but rather that the applying entity – that is, Taiwan – complies with the objectives of the World Health Organization and that its purpose and activities lie within the field of competence of the Organization. Furthermore, Taiwan, as an independent health entity, possesses fully functional responsibilities in all health matters concerning its people, including the infrastructure, workforce and scientific knowledge necessary to fulfil the objectives set out by the WHO Constitution. Global health is of highest concern to all of us and Taiwan takes its full share of this responsibility seriously and solemnly.

Like other responsible members of the international community, we do not see the World Health Organization as an appropriate arena in which to engage in a political debate. However, we earnestly hope that all Member States and States with observer status will unite to see that the World Health Organization fulfils its crucial mandate, thus achieving its objective of the attainment by all peoples of the highest possible level of health. According to WHO's own Constitution, Taiwan is fully qualified to participate as an observer, to contribute to and benefit from the Health Assembly and its activities.

El Sr. BÉLIZ (Panamá):

Señor Presidente: este tema ya se ha discutido profundamente y la sala se encuentra suficientemente ilustrada. Por tanto, Panamá, así como lo pidió el Paraguay anteriormente, solicita que el tema se someta a votación nominal. Ya varias delegaciones hemos solicitado que se proceda a la votación nominal.

Mr MOLCHAN (Belarus):
Г-н МОЛЧАН (Беларусь):

Спасибо, г-н Председатель.

Делегация Республики Беларусь хотела бы поздравить Вас с избранием на пост Председателя Пятьдесят седьмой сессии Всемирной ассамблеи здравоохранения.

Республика Беларусь, следуя своим международным обязательствам, безоговорочно поддерживает принцип «Один Китай». В этой связи делегация Республики Беларусь разделяет позицию Китая по вопросу придания Тайваню статуса наблюдателя при ВОЗ.

Считаем, что аргументы о неуместности включения этого вопроса в повестку дня, высказанные делегациями Кубы, Габона, Мавритании и другими, неоспоримы.

Республика Беларусь хотела бы выступить за недопущение политизации работы Всемирной организации здравоохранения и призывает государства – члены ВОЗ руководствоваться общепризнанными принципами международного права, а также уважать решения Генеральной Ассамблеи Организации Объединенных Наций и Всемирной ассамблеи здравоохранения. Таким образом, делегация Республики Беларусь поддерживает рекомендацию Генерального комитета и будет возражать против включения вопроса о придании Тайваню статуса наблюдателя при ВОЗ в повестку дня Пятьдесят седьмой сессии Всемирной ассамблеи здравоохранения.

Спасибо за внимание.

Le Professeur RASAMINDRAKOTROKA (Madagascar) :

Monsieur le Président, à l'instar de mes prédécesseurs, je tiens à vous féliciter pour votre élection à la présidence de la Cinquante-Septième Assemblée mondiale de la Santé ; mes félicitations s'adressent également aux membres du Bureau pour leur élection.

Monsieur le Président, la question concernant la participation ou non de Taïwan en tant qu'observateur a été déjà largement débattue l'année dernière lors de la Cinquante-Sixième Assemblée mondiale de la Santé. Comme Taïwan fait partie intégrante de la Chine, la délégation de Madagascar est contre l'inscription de cette question à l'ordre du jour, car elle constitue une violation flagrante de la Constitution de l'OMS et est contraire au principe de droit international. Je vous remercie de votre attention.

Dr HOSSAIN (Bangladesh):

The delegation of Bangladesh would like to be brief on this point. We have discussed it and we have heard the arguments of both sides. Mr President, you have informed this Assembly of the recommendation of the General Committee. The delegation of Bangladesh strongly supports the recommendation of the General Committee. The question of Taiwan is not a health issue. In our delegation's opinion, it is a political issue and should be discussed and debated not in the Health Assembly but in the United Nations.

We all know that United Nations General Assembly Resolution 2758 (XXVI) and World Health Assembly resolution WHA25.1 clearly establish the fact that Taiwan is a province of China and thus cannot qualify to take part independently in the activities of WHO or the Health Assembly, even as an observer.

The distinguished delegate of China has made a statement, and from this statement it is clearly shown that Taiwan has full access to the health services of mainland China and also to information

from WHO. The Director-General and his predecessors have made it very clear a number of times, that there is no problem at all for Taiwan to share WHO's medical information. Since 1997 the Taiwan-related proposals have been successively rejected by the Health Assembly seven times. Our delegation does not see any change in the situation whereby this issue can be again debated. That is why our delegation strongly opposes inviting Taiwan's participation as an observer to WHO or the Health Assembly. Our delegation once again supports strongly the recommendation of the General Committee.

Le Dr DIALLO (Sénégal) :

Monsieur le Président, permettez-moi au moment où je prends la parole pour la première fois de vous adresser mes vives félicitations pour votre élection à la présidence de notre Assemblée. Je félicite également les autres membres du Bureau et vous assure de la volonté de ma délégation de vous apporter toute sa collaboration dans la conduite de nos travaux.

Monsieur le Président, le Sénégal, comme le montre le document A57/GC/4, figure parmi les pays qui ont demandé l'inscription d'un point supplémentaire à l'ordre du jour relatif à l'admission de Taïwan en qualité d'observateur. N'étant pas situé dans la Région Asie, le Sénégal ne saurait être soupçonné d'avoir un quelconque intérêt politique ou idéologique en rapport avec sa demande d'inscription d'un point supplémentaire à l'ordre du jour. Par contre, le Sénégal s'est toujours montré respectueux des principes du droit international et a toujours oeuvré activement à la recherche de la paix partout dans le monde. Le Sénégal respecte tous les peuples et nations du monde. Conscient de ses responsabilités internationales, le Sénégal ne peut pas fermer les yeux devant une situation qui touche aux affaires du monde. Nous sommes en face d'une question concernant la santé et qui ne peut être réglée que dans le cadre d'une coopération universelle honnête dépouillée de toute arrière-pensée ou motivation idéologique ou politique.

Au moment où l'humanité est aux prises avec des maladies qui ignorent les frontières politiques et idéologiques et qui interpellent la conscience de toutes les nations, l'OMS, fidèle à sa vocation authentique de promotion et de préservation de la santé, n'a pas le droit d'ignorer une seule parcelle de la planète où vivent des êtres humains. Pour ces raisons, Monsieur le Président, le Sénégal appuie sans réserve l'admission de Taïwan à l'OMS en qualité d'observateur. Ce que demande le Sénégal, c'est un statut d'observateur à l'OMS pour 23 millions d'êtres humains, pour que ces derniers, comme chacun d'entre nous, puissent bénéficier des services de l'Organisation. Le Sénégal estime que certaines déclarations entendues ici et rejetant au nom d'une prétendue légalité internationale l'inscription d'un point supplémentaire à l'ordre du jour de l'Assemblée sont précisément contraires au droit d'Etats souverains, aux principes fondamentaux du droit international et à la Constitution et aux autres documents fondamentaux de l'Organisation. On nous dit que parce que la question revient chaque année depuis sept ans, on devrait maintenant cesser de la soumettre. Une telle assertion, Monsieur le Président, ignore totalement le droit légitime de tout Etat Membre de l'OMS de demander, comme le prévoient les textes pertinents de l'Organisation, l'article 12 du Règlement intérieur de l'Assemblée de la Santé notamment, l'inscription d'un point supplémentaire à l'ordre du jour. Pour le Sénégal, parler de santé n'est ni une menace à la paix ni une question politique. Je vous remercie.

M. OLANGUENA AWONO (Cameroun) :

Monsieur le Président, la délégation du Cameroun vous félicite pour votre élection et celle de vos Vice-Présidents pour conduire nos travaux.

Au nom de mon pays, je prends la parole pour soutenir la sage décision prise ce matin de ne pas admettre Taïwan comme observateur à nos travaux. Monsieur le Président, je vous félicite pour cette première recommandation qui inaugure votre mandat à la tête de notre Assemblée. Je tiens par ailleurs à rappeler que, jusqu'à preuve du contraire, le système des Nations Unies est organisé avec une hiérarchie institutionnelle que nous sommes tous tenus de respecter. Beaucoup de collègues l'ont dit, l'Assemblée générale des Nations Unies a pris une position définitive sur cette question en reconnaissant la République populaire de Chine comme le seul représentant légitime du peuple chinois. Pour nous, cette décision définitive est légale. Notre devoir est de la suivre rigoureusement.

En outre, il est clair que la République populaire de Chine est responsable de l'état de santé de son immense population ; elle assume cette responsabilité avec efficacité et personne ne saurait soutenir qu'elle serait incapable de faire bénéficier à la province de Taïwan des avantages concédés dans ce domaine au reste de sa population, conformément aux normes de l'OMS. La délégation chinoise nous en a donné du reste toutes les assurances. Il est donc temps qu'on arrête de distraire nos travaux qui ont un contenu technique et scientifique pour la promotion de la santé dans le monde pour des considérations politiques.

Enfin, combien de temps, Monsieur le Président, faudra-t-il que cette question soit rejetée pour qu'elle ait autorité de chose jugée et ne soit plus présentée ? Il est évident que l'échec appelant toujours l'échec, au moins souvent, la motion introduite pour Taïwan va encore échouer, et ce pour la huitième fois. C'est pourquoi le Cameroun recommande une résolution ferme de notre Assemblée pour que nos travaux ne connaissent plus et n'examinent plus jamais cette question qui prend une place considérable dans notre ordre du jour. Je vous remercie de votre attention.

Le Dr BODZONGO (Congo) :

Au nom du Congo, je prends la parole et je serai très bref pour dire que, année après année dans cette même salle, cette question s'est posée et, au vu des arguments avancés par les uns et les autres, elle a été rejetée. Aujourd'hui, nous avons l'avantage de prendre la parole après plusieurs délégations. Nous constatons en effet que les conditions n'ont pas changé, que les arguments sont les mêmes et que, par conséquent, rien ne peut amener l'Assemblée à changer d'avis. Donc, je suis, au nom de mon pays, d'accord avec la décision prise par le Bureau ce matin de ne pas inscrire cette question à l'ordre du jour. Je vous remercie.

El Dr. GONZÁLEZ GARCÍA (Argentina):

Señor Presidente: por supuesto que nuestro país se siente muy bien representado por su Presidencia y también que sostiene la posición tradicional de la Argentina que es el pleno apoyo a una sola China y al sostenimiento de esta voluntad que es una voluntad de las Naciones Unidas.

Quisiera hacer unas reflexiones en función de algunas propuestas que han hecho Sudán, Zimbabwe, Tailandia, entre los que me acuerdo, Congo. Creo que estamos en un incumplimiento muy importante en el día de hoy. En primer lugar estamos incumpliendo nuestros reglamentos; en segundo lugar estamos incumpliendo las decisiones de la Mesa; en tercer lugar estamos incumpliendo nuestra disponibilidad de tiempo; y en cuarto lugar, y creo que es la prueba del peor de los incumplimientos, estamos incumpliendo los objetivos de esta reunión. Se dijo que incluir o no incluir a algunas delegaciones como observadores sería una amenaza para la salud. Yo creo que lo que estamos haciendo hoy es una amenaza para la salud, porque no estamos hablando de salud y hemos consumido gran parte del tiempo en cuestiones que están fuera de acá. Por eso, ratifico la posición del Gobierno argentino, y creo que debemos abocarnos a los temas que debemos considerar en esta Asamblea.

The PRESIDENT:

We have 24 more speakers now and, as I said before, we have an extremely heavy agenda for the health matters concerning our Health Assembly. We will do what you want but I leave the judgement to you.

Mr THOMPSON (United States of America):

The United States of America fully supports the participation of Taiwan in the work of WHO, including observer status for Taiwan at the Health Assembly.

Global public health can only be advanced through participation and interaction with WHO by the people of Taiwan in an appropriate way. When you look at the people in the organizations that have observer status, the 23 million people in Taiwan are more than all of the other individuals making up all the observer status group. Taiwan has a lot to offer, having shown that it has advanced and

undertaken commitments in many respects and addressed important infectious and noncommunicable diseases, but that is not a primary reason to grant observer status. Taiwan has benefits to receive also, and a seat at the table as an observer will facilitate that. This can only better the effective actions to address the increasingly complex issues in international public health, including the emergence of SARS, avian influenza and other infectious and noncommunicable diseases. We do not support membership because Taiwan does not qualify to be a Member of WHO. The people of Taiwan deserve to have an opportunity to observe. The Health Assembly makes a distinction between membership and observership and should not deny Taiwan's legitimate interaction with WHO.

We fully support the "one China" policy, but there is no denying the fact that Taiwan, with 23 million people, could contribute and has contributed in many ways, especially during the last episode of SARS. A lot of us were very much involved in that particular disease outbreak and every single person in the world received some benefit from the SARS episode because Taiwan was consulted. It is not fair to deny it the right to be an observer and I believe 23 million people deserve that opportunity, so I will be voting on behalf of the United States for that position.

Mr ACHARYA (Nepal):

State sovereignty is the fundamental basis of membership of the United Nations. The Government of the People's Republic of China is the sole and legitimate representative of China. This issue was resolved a long time ago: in fact about 30 years ago, in the United Nations General Assembly as well as in the Health Assembly. We believe, like many other countries, in a "one China" policy. There is only one China: there is not one China and one Taiwan. Therefore, I see no justification for inviting Taiwan to be an observer. The Health Assembly cannot be a forum for back-door entry to the United Nations system. As such, we support the recommendation of the General Committee.

Mr UMER (Pakistan):

It is most distressing – in fact, it is highly regrettable – that this solemn assembly comprising health ministers and senior health officials is being subjected once again to a tedious, monotonous and tiring spectacle of political gamesmanship. I think we owe a debt of gratitude to one speaker who spoke in favour of Taiwan, saying he was doing so because of the assistance which his country receives from Taiwan. I think we must salute this delegation for sharing the truth with all of us. There was another delegation which talked about the morality of this issue. I think it is quite clear that trying to bring Taiwan into the World Health Organization is both morally wrong and politically wrong. It is morally wrong because there are two billion people in the developing world who are deprived of any kind of health cover, hundreds of millions of people in developing countries who suffer from serious disease, tens of millions of people who die every year because of the lack of medicine. We have been in session for the past nine hours. What have we done for these people, which is the real business of this Health Assembly? I think we will be judged by this behaviour and we have spent all this time addressing the health concerns of 20 million-odd rather healthy Taiwanese. It is morally wrong because it is motivated by political considerations and not by health considerations. It is also politically wrong because it is against the Charter of the United Nations. The Charter of the United Nations prohibits any action which interferes with the sovereignty of any State. The General Assembly of the United Nations, which is the supreme organ of the United Nations system, has made it very clear that all representational authority for the whole of China rests with the Government of the People's Republic of China – and we are questioning that. It is politically improper, politically incorrect to do so. Finally, in the interests of time, we have a very clear decision from the General Committee. It debated this issue for nearly three hours. Fifty speakers participated in that discussion and the General Committee reached a unanimous conclusion, which was not challenged, that this proposal should not be included in the agenda of this Health Assembly. We will strongly urge that we respect this unanimous decision of the General Committee.

El Sr. FERREIRA CACHEU (Guinea-Bissau):

Señor Presidente: Taiwán es, según las Naciones Unidas, una provincia de China. El Gobierno de la República Popular China es soberano y decide sobre sus provincias. Apoyamos el principio de una sola China. Igual que Cuba, el Camerún o la Argentina, apoyamos la moción de China continental.

El Dr. CAPELLA MATEO (Venezuela):

La delegación de Venezuela felicita la acertada decisión y designación suya como Presidente. Queremos señalar la preocupación que tiene la delegación de Venezuela por quienes por esa especial condición y mentalidad democrática de quienes cuando ganan están de acuerdo y cuando pierden arrebatan y promueven un show como quienes iniciaron este deshonroso debate que estamos dando esta tarde, perdiendo precioso tiempo justamente para discutir y hablar a lo que vinimos desde muy lejos: a hablar sobre salud en esta reunión.

Nos preocupa justamente que en nombre de un interés político se pretenda legalizar lo que cualquier grupo insular en el planeta pudiera circunstancialmente aspirar a estar presente en cualquier ámbito internacional. También pudiera pretenderlo Puerto Rico y sin embargo aquí no está presente. Eso podría ocurrir en cualquier momento y por supuesto todos sabemos que podría ocurrir. Creemos que exactamente aquí se ha producido una intervención acertada, como es la argumentación del delegado de Tuvalu. Sería bien bueno que quienes de alguna manera así piensan imitasen esta acertada intervención. Yo creo que existe, como así lo creen en nuestro Gobierno, en nuestro país, que existe una sola China y nosotros ratificamos nuestra posición internacional en este sentido.

Somos respetuosos de los principios democráticos. Si esta mañana estuvimos de acuerdo en saludar unánimemente que una Mesa tomase decisiones sobre cuál debe ser nuestra agenda, lo correcto y lo justo es que se asuma la decisión de esta Mesa y la delegación de Venezuela así lo asume. Asumimos la decisión que tomó la Mesa esta mañana.

El Sr. GONZÁLEZ SANZ (Costa Rica):

Señor Presidente: mi delegación se suma a las muchas otras que han apoyado la invitación a favor de Taiwán, y deja constancia de su pesar por no ver reflejado en el orden del día de esta Asamblea el tema de Taiwán. Lamentamos la decisión de excluir esta temática, pues no deja de ser una realidad que Taiwán cumple con todos los requisitos suficientes para tomar parte en esta Organización, de la cual fue uno de sus pioneros y es una potencia en materia de salud.

Mi delegación parte del principio de que los ciudadanos de todos los pueblos tienen derecho a disfrutar de un adecuado nivel de salud. Excluir a Taiwán de su derecho de formar parte de esta Organización como observador significa negar la oportunidad a más de 23 millones de personas de disponer de la adecuada información científica y de los recursos humanos y técnicos para atender las necesidades diarias y excepcionales en el campo de la salud. Además, para la comunidad internacional es una pérdida no poder gozar plenamente de los conocimientos y recursos que en el campo de la salud ha alcanzado Taiwán, el cual disfruta de uno de los índices más elevados de desarrollo humano.

Taiwán ya forma parte de otras organizaciones internacionales y no sobra señalar los aportes que ese país ha prestado a objetivos de asistencia humanitaria en distintas partes del mundo, lo que pone en evidencia su profundo espíritu de solidaridad por las nobles causas de la OMS y que esta institución ha impulsado. Los acontecimientos del año anterior con la epidemia del SRAS y más recientemente con la gripe aviar son ejemplos de que la comunidad internacional no puede excluir a ningún pueblo de la asistencia y cooperación médica. Ha llegado la hora de que las legítimas aspiraciones de los taiwaneses se vean reflejadas en los trabajos de esta Organización, y solicitamos que se incluya este tema en el orden del día, al igual que de conformidad con el artículo 74 del Reglamento Interior de la Asamblea Mundial de la Salud solicitamos una votación nominal de inmediato.

The PRESIDENT:

There has been a motion under Rule 63 for the closure of the debate. Does the Assembly agree with this proposal to stop the debate now and proceed directly to a vote on the recommendation of the General Committee?

Dr EL TAYEB (Egypt): الدكتور محمود ناصر الطيب (مصر):

السيد الرئيس،

أشكركم على إعطائي الكلمة وانتهز هذه الفرصة لأهنئكم بانتخابكم رئيساً لجمعية الصحة العالمية السابعة والخمسين ونعدكم بمساندة كاملة من وفد جمهورية مصر العربية.

السيد الرئيس، لا يرحب وفد جمهورية مصر العربية بالتصويت على توصية اللجنة العامة بعدم طرح مسألة العضوية المراقِبة لتايوان وذلك للسببين التاليين: أولا: إن طلب التصويت في هذه الحالة إنما يمثل تحديا لقرار اللجنة العامة التي أوكلت إليها الجمعية البت بالنيابة عنها في مثل هذه المسائل، خاصة وأن اللجنة العامة جهاز تمثيلي متوازن تمثل فيه كافة أقاليم هذه المنظمة ومن ثم فإن قرارها يعبر عن رأي الدول الأعضاء جميعا، ثانيا: لا يجوز التصويت على مسائل لا تتفق مع دستور هذه المنظمة أو هذه الجمعية ولا تتفق مع قرارات جمعية الصحة العالمية ولا مع قرارات الشرعية الدولية والأمم المتحدة والقانون الدولي.

بناءً عليه فإن وفد مصر لا يرى مناسبة للتصويت في هذا الشأن على مسألة تتعارض بوضوح مع ما استقرت عليه الشرعية الدولية، بما فيها جمعية الصحة العالمية وقراراتها التي أمنت، في كل الأحوال، على مبدأ الصين واحدة.

وإذ نرفض التصويت على توصية اللجنة العامة بعدم إدراج طلب العضوية المراقِبة لتايوان على جدول أعمالنا فإننا نرحب بالموقف النبيل للصين الشعبية التي أعلنت حكومتها عما تقدمه من مساعدة ودعم للأوضاع الصحية للسكان في تايوان كما أنها لا تقف حائلاً دون تقديم منظمة الصحة العالمية لنفس الدعم الصحي لتايوان.

شكرا سيدي الرئيس.

Mr KONCHELLA (Kenya):

I wish to support the Egyptian position that we should not take a vote on the recommendation of the General Committee because I have given sufficient reason for us to move on. However, I wish to state Kenya's position. Kenya's position is that we support the "one China" policy and the recommendation of the General Committee that we exclude the application of Taiwan for observer status from our agenda. We have spent enough time on this issue and should now move on to discuss other issues.

Mr TOPPING (Legal Counsel):

After listening to the interventions of Egypt and Kenya, I thought I should try to clarify the situation somewhat. There has been, as you know, a recommendation by the General Committee which has been put to this plenary. There have been at least two calls for a vote on this recommendation. Had no one called for a formal vote, it might have been possible, as in previous years, for the President, after hearing an exchange of views, to then ask the plenary whether it was prepared to accept the recommendation of the General Committee. The calls by these delegations to have a vote, and that this vote be recorded as a roll-call vote, no longer make that an option. There will have to be a vote; there has been a motion for closure of the debate. The President tried to see whether we could simply agree to close the debate without having to have a vote on that motion and for that reason he was asking whether we could just close the debate now. He can give the floor to two

speakers speaking against it, but if no one is against it – in other words, when he re-puts this question to you in a minute – if no one objects we can then proceed to the vote. We will have to have a vote.

El Sr. MORA GODOY (Cuba):

Señor Presidente: desafortunadamente la confusión sigue reinando y quisiera realmente, para beneficio de todo el mundo, de todos los Estados Miembros que se van a enfrentar a una votación innecesaria, que se nos indique si realmente tenemos que ir a una votación, en primer lugar sobre el texto, es decir sobre la propuesta de adición de un tema adicional, porque lo que tiene entendido mi delegación es que el Presidente presentó una recomendación que viene de la Mesa. Por tanto, lo que corresponde es que cualquier país que estuviera en contra de esa recomendación tendría que retarla. Eso es lo que entiende mi delegación en los procedimientos, y quisiera una aclaración de cómo vamos a proceder exactamente.

Mr TOPPING (Legal Counsel):

The President asked, at the beginning of this debate, whether the recommendation of the General Committee not to include this item on the supplementary agenda was acceptable. In response, there were a number of delegations taking the floor, some in favour, some against, but more than one – I believe two – specifically said that, in addition to not agreeing with that recommendation, they were asking for a vote. Therefore it is not possible for the President to assume that there is a consensus to accept that recommendation. That was the position I was operating on: that there had been a clear request by more than one delegation for a vote and that that vote be done as a roll-call vote. Just to make it clear: that particular vote would be a vote on the recommendation of the General Committee. Where we are at this stage, and I repeat this, there has been a motion under the Rules of Procedure to stop the debate and move directly to that vote. If the plenary is agreeable to stopping the debate, then when the President asks again, "Do we agree to close the debate now?", and if no one objects, we can then move directly to the vote.

The PRESIDENT:

I will just read that again. There has been a motion under Rule 63 for the closure of the debate. Does the Assembly agree with this proposal to stop the debate now and proceed directly to vote on the recommendation of the General Committee?

El Sr. GONZÁLEZ SANZ (Costa Rica):

Señor Presidente: lo que quiero aclarar es que yo no pedí el cierre del debate. Si se estaba interpretando de mi intervención que yo pedí el cierre del debate eso es incongruente con lo que yo pedí. Yo pedí que en el momento en que se diera la votación, de conformidad con el artículo 74, fuera nominal, pero no he solicitado el cierre del debate, si se refiere a mi intervención.

The PRESIDENT:

In that case we continue with the debate.

Dr TANGI (Tonga):

Thank you very much, Mr President. I really feel sorry for you. I spent the last 32-and-a-half hours travelling around the world to come to this meeting, only to spend the whole of the first afternoon talking about this issue, which is not even on the agenda. My country fully supports the "one China" policy – that is my position on this – but I would like to ask the President and the Legal Counsel why it is that we have to vote just because two countries recommended a vote. In previous years we discussed the same issue and then we moved on: we did not vote. Now two countries

recommended a vote and two other countries recommended not to vote. The Legal Counsel said we have to vote. I do not think that we have to vote on this, and I share the view that we have said enough on this issue, more than enough. We want to hear the address by the Director-General. We want to hear the others. We have had enough.

Le Professeur REDJIMI (Algérie) :

Monsieur le Président, en vous félicitant pour votre élection, et en félicitant également les membres du Bureau, je voudrais rappeler que mon pays s'est toujours opposé à l'octroi du statut d'observateur à Taïwan, ainsi qu'à l'inscription de cette question à l'ordre du jour. En effet, cette demande introduite par quelques pays contrevient à toutes les données actuelles du droit international qui a reconnu la pleine souveraineté de la République populaire de Chine sur tous ses territoires en 1971 et a établi sa pleine et unique légitimité ; cette demande contrevient également aux dispositions de la Constitution de l'OMS. La proposition faite par la délégation de la République populaire de Chine d'accueillir en son sein les professionnels taïwanais est un geste politique significatif et de haute portée que nous saluons. C'est pourquoi l'Algérie appuie fortement la recommandation du Bureau de ne pas entrer en matière sur cette question. Ma délégation vous demande instamment, Monsieur le Président, de clore cette question et de faire droit à la requête de la République populaire de Chine et de la majorité des Etats Membres ici réunis de consacrer tous nos efforts à notre ordre du jour, lui même déjà chargé, et de ne pas nous disperser sur une question de portée politique et inutilement polémique. Merci, Monsieur le Président.

The PRESIDENT:

Do I understand, Algeria, that you are asking for a closure of the debate?

Le Professeur REDJIMI (Algérie) :

Oui, Monsieur le Président.

The PRESIDENT:

Now I am going to read the text for the third time so that you remember it and memorize it.

There has been a motion under Rule 63 for closure of the debate. Does the Health Assembly agree with this proposal to end the debate and proceed directly to the vote on the recommendation of the General Committee? I see no objection. It is so decided.

Mr SHA Zukang (China):

I asked for the floor on a point of order. I raised my name card before the distinguished representative of Algeria. Having heard the statement of the distinguished representative of Tonga, I decided to raise a point of order. If I remember correctly, the distinguished representative asked a couple of questions. There are three scenarios. He mentioned the first scenario, that for many years – six or seven years – the General Committee adopted the recommendation and the recommendation was presented to the Health Assembly. Subsequently, the Health Assembly agreed to it despite a few dissenting voices, and there has never been a vote. This is the background. Do we stick to this same practice? Despite some opposition or dissenting voices there was no vote. Second, right now we have two proposals on the table. One is, as I understand – I forgot who made the proposal – Egypt? – to vote on the proposal by a few countries requesting the invitation of Taiwan to participate in this Health Assembly. I take this as a proposal. Of course, we all know this proposal was rejected unanimously by the General Committee. But there is a proposal here on the table and if I am not mistaken, there is another proposal to vote on the recommendation which was adopted unanimously by the General Committee. Am I correct in saying that we have three options in front of us here? I remember that the Legal Counsel said that if there is to be a vote, it will be on the recommendation of the General

Committee and, in practice, there has never been a vote. So we have three options in front of us. Since I am taking the floor on a point of order, I need to have this clarified because once we take the decision, I will ask for the floor to speak on the substance of the matter.

Mr TOPPING (Legal Counsel):

I would not say that we have three options as such. Before I deal with the issue of whether we need to go to a vote, let me deal with what proposal is before the Assembly.

Several Member States made a proposal in accordance with Rule 12 of the Rules of Procedure for the addition of a supplementary agenda item on inviting Taiwan to participate in the Health Assembly as an observer. In accordance with the Rules of Procedure, the General Committee considers that question first and then makes a proposal for or against it, which is the proposal that is put before the Health Assembly. I did not understand that the delegation from Egypt was actually trying to make another proposal. If they were, I would say that it does not affect the fact that the sole proposal that the plenary is to vote or to decide upon now is the recommendation of the General Committee. We had this debate in 1997 when this question came before the Assembly for the first time and it was clarified then. Only the recommendation of the General Committee is to be considered by the plenary.

On the issue of whether one needs to go to a vote or not, I have been listening to the same debate as everyone else, and in response to the President's question of whether the plenary agrees to accept the recommendation of the General Committee, two delegations, in addition to saying they did not like that recommendation, called for that recommendation to be put to a vote. There has been a long debate. There is nothing to prevent the President from ascertaining, now that we have voted to close the debate, whether the plenary (or any Member State) still wishes to insist on a vote. If no-one insists on a vote, it is possible for the plenary to accept the recommendation of the General Committee by consensus. But consensus is not possible if someone says they insist on the vote. In the interest of time, the President can always exercise his discretion and just re-put the question, not for a long procedural debate on the merits of the recommendation, but rather to clarify whether anyone still insists on exercising their right to vote.

In summary, there is one proposal before the plenary. It is open to the President, if he wishes, to ask for the purpose of clarification whether the plenary now, after having listened to everyone, is prepared to accept the recommendation of the General Committee without going to a formal vote.

The PRESIDENT:

I will just come back to what we have decided. Can I have your attention, please? As a matter of clarification, can I ask the plenary whether it is prepared now to accept the General Committee's recommendations not to include this item, without proceeding to a formal vote?

Mr BÉLIZ (Panama):

Panama still wants to call for a vote, a nominal vote.

Dr EL TAYEB (Egypt):

Actually, we now have two proposals on the table. A proposal to vote on the recommendation of the General Committee, which was presented by several delegations, and another proposal, made by Egypt and supported by many other delegations, not to vote on the recommendation. So, if there will be any voting right now, it should be on whether the proposal made by some delegations to vote on the General Committee recommendation would be taken or not. Therefore, we should be voting on the proposal of delegations to vote, but not starting immediately to vote on the recommendation of the General Committee. I hope I have made myself clear.

Mr TOPPING (Legal Counsel):

As I understand the intervention of Egypt, it is to vote on whether or not to have a vote. Frankly, I do not see the sense of that at all. There is a proposal, a recommendation from the General Committee, and this plenary needs to decide what to do with that recommendation. The President has asked twice whether we can accept this recommendation without proceeding to a formal vote; in other words, by consensus. That is a possibility as long as no-one objects. Someone objected twice and so there has to be a vote.

The PRESIDENT:

I just want to say a few words, if you would give me the opportunity. I know exactly how Members feel. I agree with the delegate of Tonga that a lot of people have come from a long, long way away. I request every delegate to keep the harmony and focus in mind. There has been a recommendation by the General Committee, which you constituted, so I will ask you one more time and then whatever you say will be done. So, in the name of harmony, and much more, so that we can go ahead with our work, can I ask the plenary whether it is prepared now to accept the General Committee's recommendation not to include this item, without proceeding to a formal vote?

Dr PENDAME (Malawi):

After listening to the arguments for and against and given the time we have spent on the matter, I think that it would be fair to go to a vote and resolve the issue once and for all.

Dr KASSAMA (Gambia):

I think that it is not right for this debate to remain in a deadlock like this. I want to use my right as the head of the delegation of Gambia, in order to avoid further delay, to recommend that we move to a vote and finish with this.

Mr SELIM-LABIB (Egypt):

I am afraid that it is not my delegation that is responsible for this confusion. I wonder where there is a consensus in this room on the proposal to vote on the recommendation of the General Committee. There is no consensus on the proposal to vote. Therefore my delegation requests a vote on that proposal. I hope I am clear now.

Ms MOTSUMI (Botswana):

Before we proceed with a vote, could it be made abundantly clear what is meant by a nominal vote? Thank you.

Mr TOPPING (Legal Counsel):

There are two points I will address. One is the point again raised by Egypt. I do not consider his request to vote on whether or not to vote on the General Committee's recommendation to be a valid request. Mr President, I would advise you to rule that we are at this stage in the position where we are going to vote on the recommendation of the General Committee. If the plenary does not accept that, it would have to try to overrule you by an appeal, at which point we would have to have a vote. So, therefore, to move things forward I would suggest that you be very clear in making a decision now. I would advise you that on the basis of the Rules of Procedure it is the sovereign right of a Member State to insist upon a vote. You have tried several times to have the recommendation of the General Committee adopted by consensus. That has not proved possible and therefore we now must move to a vote on the recommendation of the General Committee, and I suggest that you make that your ruling.

On the question of what is a nominal vote, it is a roll-call vote in which each person, each Member State that is entitled to vote, will be called out by name, and the vote will be noted in the record.

The PRESIDENT:

Considering what has transpired, I do believe the Legal Counsel says that I have to make a ruling which would be that we go forward to vote on the recommendation of the General Committee; so let us proceed.

I will give the floor to the Legal Counsel to explain the procedures.

Mr TOPPING (Legal Counsel):

Thank you, Mr President. Now that you have ruled that we are proceeding to a vote on the recommendation of the General Committee, let me explain what will happen next.

There has been a request for a roll-call vote. That means that in a few minutes you will draw from a bag a letter that will determine which country will be called on to vote first. We will then call out in French alphabetical order the names of all those Member States entitled to vote. At that point each Member State would indicate its vote in favour, its vote against or its abstention. I will explain again what we are voting on and what voting in favour means. The decision will be made by a majority vote; if you abstain, that does not count for the determination of what is a majority. The majority is of those present and voting; so only those Members casting a valid affirmative or negative vote will be counted.

I will now read out the list of Member States which have been deprived of the right to vote because of previous Health Assembly resolutions, so their names will not be called out: Afghanistan, Antigua and Barbuda, Argentina, Armenia, Central African Republic, Chad, Comoros, Dominican Republic, Georgia, Guinea-Bissau, Iraq, Kyrgyzstan, Liberia, Nauru, Niger, Republic of Moldova, Somalia, Suriname, Tajikistan, Togo, Turkmenistan, Ukraine.

Now let me explain precisely what you are voting on when we say that you are voting on the recommendation of the General Committee not to include this item as a supplementary agenda item. If you vote "yes", that is in favour of the recommendation of the General Committee not to include this item as a supplementary agenda item. If you do not like the recommendation of the General Committee and you would rather have inviting Taiwan as an observer added to the agenda, you would vote "no". Is that clear? All those voting "yes" are voting in favour of the General Committee recommendation not to include this item on the agenda. Mr President, I would ask you to draw a letter out of the bag. The letter is Y and so we will start with Yemen.

The PRESIDENT:

There is a point of order by Belarus.

Mr MOLCHAN (Belarus):
Г-н МОЛЧАН (Беларусь):

Спасибо, г-н Председатель.

У нашей делегации возник чисто юридический вопрос, который мы бы хотели задать вашему юридическому советнику.

Дело в том, что доклад Комитета по проверке полномочий будет сделан только завтра, и сегодня говорить о том, что некоторые делегации некоторых стран имеют действительно право на голосование, я думаю, еще рано.

Спасибо.

Mr TOPPING (Legal Counsel):

I would like to thank Belarus for asking that question. I should have mentioned that issue. There are two different issues. One is the right to vote and whether that has been suspended because a Member State has fallen into arrears with its contributions to WHO and therefore has lost its right to vote through a decision of the Health Assembly. The other is the matter of the report of the Committee on Credentials, where the credentials of each of the Member States are assessed and then reported to the plenary on Wednesday. In the situation where there has been no report as yet of the Committee on Credentials, it is the consistent practice that everyone in the room is considered to have valid credentials, so the issue of credentials is not an issue at this moment today. That does not change the fact that prior Health Assembly resolutions have deprived certain Member States of the right to vote. That would apply whether it is today or later on in the week. I hope that has clarified the situation and we can proceed now to the vote.

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

The result of the vote was as follows:

In favour: Albania, Algeria, Angola, Australia, Austria, Azerbaijan, Bahamas, Bangladesh, Barbados, Belarus, Belgium, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burundi, Cambodia, Cameroon, Canada, Cape Verde, Chile, China, Colombia, Congo, Cook Islands, Côte d'Ivoire, Croatia, Cuba, Cyprus, Czech Republic, Democratic People's Republic of Korea, Democratic Republic of the Congo, Denmark, Djibouti, Ecuador, Egypt, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Finland, France, Gabon, Germany, Ghana, Greece, Guinea, Guyana, Hungary, Iceland, India, Indonesia, Iran (Islamic Republic of), Ireland, Italy, Jamaica, Jordan, Kazakhstan, Kenya, Kuwait, Lao People's Democratic Republic, Latvia, Lesotho, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Madagascar, Malaysia, Maldives, Mali, Malta, Mauritania, Mauritius, Mexico, Micronesia (Federated States of), Monaco, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nepal, Netherlands, New Zealand, Nigeria, Norway, Oman, Pakistan, Papua New Guinea, Peru, Poland, Portugal, Qatar, Republic of Korea, Romania, Russian Federation, Rwanda, Saint Lucia, Samoa, San Marino, Saudi Arabia, Serbia and Montenegro, Seychelles, Sierra Leone, Singapore, Slovakia, Slovenia, South Africa, Spain, Sri Lanka, Sudan, Sweden, Switzerland, Syrian Arab Republic, Thailand, Timor-Leste, Tonga, Tunisia, Turkey, Uganda, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, Uruguay, Venezuela, Viet Nam, Yemen, Zambia, Zimbabwe.

Against: Belize, Burkina Faso, Costa Rica, El Salvador, Gambia, Grenada, Guatemala, Haiti, Honduras, Japan, Kiribati, Malawi, Marshall Islands, Nicaragua, Palau, Panama, Paraguay, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Sao Tome and Principe, Senegal, Solomon Islands, Swaziland, Tuvalu, United States of America.

Abstaining: Israel, Philippines.

Absent: Andorra, Bahrain, Dominica, Fiji, Lebanon, Niue, The former Yugoslav Republic of Macedonia, Trinidad and Tobago, Uzbekistan, Vanuatu.

The proposal was therefore adopted by 133 votes to 25, with 2 abstentions.

Il est procédé à un vote par appel nominal, les noms des Etats Membres étant appelés dans l'ordre alphabétique français. Le premier appelé est le Yémen, la lettre « y » ayant été choisie par tirage au sort.

Le résultat du vote est le suivant :

Pour : Afrique du Sud, Albanie, Algérie, Allemagne, Angola, Arabie saoudite, Australie, Autriche, Azerbaïdjan, Bahamas, Bangladesh, Barbade, Bélarus, Belgique, Bénin, Bhoutan, Bolivie,

Bosnie-Herzégovine, Botswana, Brésil, Brunéi Darussalam, Bulgarie, Burundi, Cambodge, Cameroun, Canada, Cap-Vert, Chili, Chine, Chypre, Colombie, Congo, Côte d'Ivoire, Croatie, Cuba, Danemark, Djibouti, Egypte, Emirats arabes unis, Equateur, Erythrée, Espagne, Estonie, Ethiopie, Fédération de Russie, Finlande, France, Gabon, Ghana, Grèce, Guinée, Guinée équatoriale, Guyana, Hongrie, Iles Cook, Inde, Indonésie, Iran (République islamique d'), Irlande, Islande, Italie, Jamahiriya arabe libyenne, Jamaïque, Jordanie, Kazakhstan, Kenya, Koweït, Lesotho, Lettonie, Lituanie, Luxembourg, Madagascar, Malaisie, Maldives, Mali, Malte, Maroc, Maurice, Mauritanie, Mexique, Micronésie (Etats fédérés de), Monaco, Mongolie, Mozambique, Myanmar, Namibie, Népal, Nigéria, Norvège, Nouvelle-Zélande, Oman, Ouganda, Pakistan, Papouasie-Nouvelle-Guinée, Pays-Bas, Pérou, Pologne, Portugal, Qatar, République arabe syrienne, République de Corée, République démocratique du Congo, République démocratique populaire lao, République populaire démocratique de Corée, République tchèque, République-Unie de Tanzanie, Roumanie, Royaume-Uni de Grande-Bretagne et d'Irlande du Nord, Rwanda, Sainte-Lucie, Saint-Marin, Samoa, Serbie-et-Monténégro, Seychelles, Sierra Leone, Singapour, Slovaquie, Slovénie, Soudan, Sri Lanka, Suède, Suisse, Thaïlande, Timor-Leste, Tonga, Tunisie, Turquie, Uruguay, Venezuela, Viet Nam, Yémen, Zambie, Zimbabwe.

Contre : Belize, Burkina Faso, Costa Rica, El Salvador, Etats-Unis d'Amérique, Gambie, Grenade, Guatemala, Haïti, Honduras, Iles Marshall, Iles Salomon, Japon, Kiribati, Malawi, Nicaragua, Palaos, Panama, Paraguay, Saint-Kitts-et-Nevis, Saint-Vincent-et-les-Grenadines, Sao Tomé-et-Principe, Sénégal, Swaziland, Tuvalu.

Abstentions : Israël, Philippines.

Absents : Andorre, Bahreïn, Dominique, Ex-République yougoslave de Macédoine, Fidji, Liban, Nioué, Ouzbékistan, Trinité-et-Tobago, Vanuatu.

La proposition est donc adoptée par 133 voix contre 25, avec 2 abstentions.

The PRESIDENT:

The final vote is as follows: the number of Member States with a right to vote is 170. The number of Members absent: 10. The number of abstentions: 2. The number of votes in favour: 133. The number of votes against: 25. The number of Members present and voting: 158. The number of votes required for a majority: 80. The recommendation of the General Committee is adopted.

I would just like to leave some food for thought: this is the eighth year running this has been going on, despite the recommendation made by the General Committee. 170 countries are gathered here today from all over the world, and the whole precious day has passed. Nightfall is on the way right now and the Health Assembly has not even touched one single health matter. I just leave this for you to think about.

I give the floor to three countries on a point of explanation of their vote.

Mrs WHELAN (Ireland):

I am speaking on behalf of the European Union. The European Union maintains a "one China" policy. We have in effect voted against the inclusion of this item on the agenda. However, the European Union strongly supports the principle enshrined in the WHO Constitution that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. To that end, the European Union welcomes the access by WHO experts to Taiwan during the SARS crisis. We hope to see this cooperation strengthened and deepened to ensure that the health concerns of the people of Taiwan are met and that proper account is taken of global efforts to safeguard public health. We hope that the Secretariat and others organizing technical meetings and working groups under WHO auspices will show flexibility and find mechanisms to allow Taiwanese medical and public health officials to participate in these activities.

Dr TANGI (Tonga):

I want to get a clarification from the Legal Counsel as to whether the result that was just announced will become a policy of this body from now on, a standing policy, or whether we are going to be exposed to the same thing all over again. Now that we have put this issue to a vote and this Health Assembly has said what it wants, are we going to make that a policy from now on or not?

Mr SOBASHIMA (Japan):

Japan's explanation of vote is as follows: in view of the universality of WHO as an international organization, the Government of Japan considers it desirable that as many countries, international organizations, nongovernmental organizations and others as possible participate in the activities of WHO. It also has a strong interest in the improvement of the health and medical situation in Taiwan, which is geologically adjacent to Japan. From these perspectives, Japan considers it desirable that Taiwan be able to participate in WHO as an observer in some form, in a manner satisfactory to those concerned, and that this issue should be discussed fully by the countries concerned.

Mr FERGUSON (Canada):

Canada voted to support the report of the General Committee, whose mandate is to consider all matters related to the agenda of the Health Assembly. The Committee met and gave careful consideration to this and other matters related to the Health Assembly agenda, and Canada therefore accepts the recommendations of the General Committee in its report to the plenary. A solution to Taiwan's desire for status at WHO should be achieved through a pragmatic and non-politicized process that does not detract from the core mandate of this Organization. Canada would support a formula for Taiwan's participation as long as this formula was in accordance with WHO constitutional rules and procedures and had received the broad-based approval of WHO Members. A lack of representation at the Health Assembly should not prevent anyone from enjoying the assistance in health matters that WHO provides. We encourage WHO to take all measures possible under current circumstances to ensure that Taiwan is provided with all the ongoing benefits of its advice and assistance. Canada has been pleased to work with WHO and those concerned to provide such assistance to the people of Taiwan, particularly in times of health crises such as the SARS and avian influenza epidemics. We will continue to do so.

Mr SIAFAUSA VUI (Samoa):

Samoa voted in favour of the recommendation on the understanding that China has opened its arms to welcome Taiwanese people to be in its delegation to WHO. Since we have spent the whole afternoon on this issue, Samoa would like to move a motion, in the light of today's vote, that this matter should never be brought up again in future in WHO.

Mr ABIDOV (Uzbekistan):

I took the floor just to say that since we missed the voting for technical reasons, we want to vote "yes" to support the recommendation of the General Committee not to include this item on the agenda.

El Sr. CASTILLO PEREIRA (Nicaragua):

Señor Presidente: quisiéramos en ese sentido explicar y razonar nuestro voto. Mi delegación considera que la participación de Taiwán en estos debates es crucial, oportuna y necesaria, e insiste en que no conocer de fuentes directas sus preocupaciones, estrategias o programas, entre otras actividades relativas a la salud, podría ir en contra de los intereses de cada uno de los Estados que estamos representados en esta Asamblea.

Señor Presidente: congruente con el espíritu humanitario y de colaboración que caracteriza a esta Organización y con lo establecido explícitamente en sus principios, el goce de grado máximo de salud que se puede lograr es uno de los derechos fundamentales de todo ser humano sin distinción de raza, religión, ideología política o condición económica o social. Mi delegación desea expresar su profunda aspiración en el futuro de incluir el tema de Taiwán como punto del orden del día.

Mr TOPPING (Legal Counsel):

There have been two requests, if I understand correctly, for an opinion on whether the decision of the plenary not to add the subject of inviting Taiwan as an observer to the Health Assembly as a supplementary agenda item for this Health Assembly somehow applies to future Health Assemblies. The very short answer is "no", it does not apply to future Health Assemblies. Each Health Assembly is sovereign unto itself to decide its agenda at each particular session.

The PRESIDENT:

May I therefore assume that the Health Assembly agrees to adopt the provisional agenda as amended, to omit the four items we agreed to at the start of our meeting this afternoon, and to include a supplementary item, "Eradication of dracunculiasis"? It is so decided.

On allocation of items to the main committees, the provisional agenda of the Health Assembly was prepared by the Executive Board in such a way as to indicate a proposed allocation of items to Committees A and B on the basis of the terms of reference of the main committees. Since the Health Assembly has just approved the inclusion of a supplementary item on eradication of dracunculiasis in its agenda, it is proposed that this item be allocated to Committee A. It is understood that later in the session it may become necessary to transfer items from one committee to the other, depending on each main committee's workload. The General Committee will meet again on Wednesday, 19 May to review progress in dealing with the agenda, and to make any adjustments to the allocation of the items to committees, or to the timetable, that are necessary. With regard to item 10 of the provisional agenda, "Round tables: HIV/AIDS", the General Committee made the following proposal reflecting the approach of previous years. On Tuesday morning there will be four concurrent round tables on HIV/AIDS. Each of these round tables will be considered as a separate committee of limited membership. Membership will be limited to those ministers of health or delegates designated to represent the ministers at this Health Assembly who have registered with the Secretariat. The list of participants in each of the round tables is published in the Journal. As I have already said, only these participants will be considered as members of each round table. All the delegations and observers to the Health Assembly, including members of the delegation of the minister of health participating in the round tables, would attend as observers. Consequently, only the participants – that is to say the ministers of health or those designated by them – constituting the membership of each round table will be permitted to speak, with the objective of ensuring full debate among all participants. As the purpose of the round tables is to permit everyone to profit from an exchange of views among the participants, and not necessarily to reach an agreed position on all cases, the round tables do not have a mandate to adopt resolutions, but rather only to submit a summary of the discussions to the plenary. The General Committee has proposed the following Ministers of Health present at this Assembly as Chairmen of the four round tables: Round Table 1: Dr M. Phooko of Lesotho; Round Table 2: Dr M. Bethel of Bahamas; Round Table 3: Dr D. Keber of Slovenia; Round Table 4: Mr U. Olanguena Awono of Cameroon. The General Committee has also agreed that one of these Chairmen will provide the plenary with an oral report summarizing the discussions among the participants.

Does the Health Assembly agree with these proposals? I am so happy, I see no objection. It is so decided.

I wish now to make an important announcement concerning the annual election of Members entitled to designate a person to serve on the Executive Board. Rule 101 of the Rules of Procedure reads:

"At the commencement of each regular session of the Health Assembly the President shall request Members desirous of putting forward suggestions regarding the annual election of those

Members to be entitled to designate a person to serve on the Board to place their suggestions before the General Committee. Such suggestions shall reach the Chairman of the General Committee not later than twenty-four hours after the President has made the announcement in accordance with this Rule.".

I therefore invite delegates wishing to put forward suggestions concerning these elections to submit them to the Assistant to the Secretary of the Health Assembly not later than 16:00 on Tuesday afternoon, 18 May, in order to enable the General Committee to draw up its recommendations to the Health Assembly regarding these elections.

The meeting rose at 19:10.
La séance est levée à 19h10.

THIRD PLENARY MEETING

Tuesday, 18 May 2004, at 14:40

President: Mr Muhammad Nasir KHAN (Pakistan)
later: Dr R. MARIA DE ARAUJO (Timor-Leste)

TROISIEME SEANCE PLENIERE

Mardi 18 mai 2004, 14h40

Président: M. Muhammad Nasir KHAN (Pakistan)
puis: Dr R. MARIA DE ARAUJO (Timor-Leste)

1. INVITED SPEAKERS
INTERVENANTS INVITES

The PRESIDENT:

The Health Assembly is called to order.

The first item to be considered this afternoon is item 4, "Invited speakers" and it is a great honour for me to welcome, on behalf of this august Health Assembly, Dr Kim Dae-jung, former President of the Republic of Korea.

Born in a small village in South Korea, Dr Kim Dae-jung has become the symbol of the extraordinary economic and social progress in the Republic of Korea. He stands as a symbol for human rights and democracy through his relentless fight against military dictatorships and oppression. He is also a champion of peace and reconciliation, not least through his Sunshine policies with the neighbouring Democratic People's Republic of Korea leading up to the successful summit with the leader Kim Jong-il in June 2000.

Dr Kim was elected President of the Republic of Korea in 1997. His reconciliation policies and relentless fight for human rights and democracy led to his receiving the Nobel Peace Prize in the year 2000. He has been called the "Nelson Mandela of Asia". Today, the world needs more Nelson Mandelas, more Dr Kims, more Martin Luther Kings. It is therefore a great pleasure for me to invite Dr Kim Dae-jung of the Republic of Korea to address this Health Assembly.

Dr KIM Dae-jung (former President of the Republic of Korea):

It is an honour for me to be invited here to deliver a speech to such an illustrious gathering. I thank you.

WHO has been the saviour and the hope of mankind since its establishment in 1948. Even when the world was divided by differences in ideology and political system, WHO played a vital role in uniting the international community under its goal of improving health care for all of mankind. In particular, WHO provided its utmost support when the Korean people were struggling to recover from

the destruction and dire poverty of the Korean war in the early 1950s. I, along with the Korean people, would like to extend my sincere gratitude to WHO for its contribution.

The rapid advancement in knowledge and technology has made life more prosperous for mankind. Numerous opportunities for advancement in all human endeavours have emerged in the process of globalization. Unfortunately, such development has not produced fair benefits to all countries and to all groups of people. The divide between the "haves" and the "have-nots" is growing wider. According to recent statistics from the World Bank, 1.2 billion people live on less than one dollar a day. In sub-Saharan Africa and Latin America, the number of people suffering from poverty has increased even more since the 1990s.

Thanks to your efforts, there has been significant progress in the health sector. Overall life expectancy has increased, and we are now able to effectively control many more diseases. But these are only the success stories of the advanced countries; a great number of people around the world still do not have much access to such benefits. Such a situation is clearly evident from various indicators; the difference in life expectancy between the developed countries and the least developed countries is more than 20 years. What is so heartbreaking for us is that the socially vulnerable, including children, are suffering the most. According to WHO, around ten million people, or 20% of the 57 million people that died in the year 2002, were children under the age of five. And 98% of the ten million were children from developing countries. Human resources are the most important means for development in many of these developing countries. The suffering of our children is an indicator that hopes and dreams are vanishing from our homes, society and country.

I believe that poverty is the most serious challenge that mankind currently faces. I see it as the biggest obstacle of WHO. We are living in an era of globalization, information revolution and a knowledge-based society. But many people do not have the access or the opportunity to reap the benefits of this new age, and the wealth gap between and within countries is widening. Poverty is the primary cause of hunger and disease. A prolonged state of poverty leads to the social and cultural discrimination of the poor, which is the major obstacle to social integration. Moreover, poverty also lies at the root of religious, ethnic and cultural conflicts. Without resolving poverty, we cannot deal with terrorism, spreading confusion around the world. Poverty is an issue that needs to be urgently addressed to bring about a peaceful and cooperative community for mankind in the twenty-first century. Reducing poverty is a prerequisite for extending life expectancy and improving health conditions for the poor who make up the absolute majority of the world population.

As you well know, the Millennium Summit was held at the United Nations in September of 2000. I attended the meeting as the President of the Republic of Korea. At the Summit, the world leaders adopted the United Nations' Millennium Declaration. In the Declaration, the world leaders decided to free mankind from the suffering of poverty as an important goal for the new millennium and pledged to create environments in each country and in the international community conducive to achieving this goal. Furthermore, we set the goal of reducing by half the number of people who live on less than a dollar a day, by 2015. However, according to a recent report by the President of the World Bank, it is already becoming evident that there are difficulties in meeting this goal.

Cooperation within the international community is indispensable in the fight against poverty. Confusion and instability in one area are not confined to just that particular region but affect everywhere. It is imperative that the rich countries help the poor countries for the sake of their own stability and prosperity. There is also a need for global cooperation to resolve the inequality that has resulted from the digital divide. Meanwhile, it is essential that each country establish policies to eliminate poverty. After becoming President in 1998, I implemented the productive welfare policy to assist the poor. The productive welfare policy, first of all, provides free health-care services to the vulnerable classes in society who are incapable of supporting themselves. It provides up to US$ 800 for living costs for a family of four in South Korea. Second, this policy does not end there, but provides education to the welfare recipients so that they can find stable jobs. To adapt to the age of knowledge-based economy in the twenty-first century, computer education was advocated for all the South Korean people, from students, housewives, senior citizens, to even prisoners, soldiers and the physically challenged. Korea is now an information technology powerhouse in the world. There are many instances of children from poor family backgrounds getting good jobs and achieving great success in venture capital industries in South Korea.

Disease results in a loss in the labour force. For the poor, disease poses a threat to the very survival of the household. This situation breeds many negative consequences, sometimes forcing children into the labour force and depriving them of an opportunity for education. Disease is one of the main obstacles that stands in the way of the efforts of people in developing countries, trying to overcome poverty. Poverty accelerates the spread of disease; the spread of disease aggravates poverty, creating a vicious cycle. We all know that the sub-Saharan African countries are suffering from the rampant spread of HIV/AIDS. More than 30 new strains of viruses, such as severe acute respiratory syndrome and avian influenza, have appeared during the past 30 years. Even more serious is the problem of not being able to find cures for them.

In this regard, I would like to applaud the work of WHO in promoting the well-being and the health services of mankind by strengthening international cooperation in the public health sector. I would also like to commend the Director-General for his efforts in fighting infectious diseases such as poliomyelitis for 20 years in WHO. I have high hopes for the "3 by 5" initiative which plans to treat three million HIV/AIDS patients by 2005, and other core initiatives of WHO, being pursued actively since the inauguration of Dr Lee.

I especially extend my gratitude to WHO for its support to North Korea and hope that it can play an active role in improving the still-rudimentary public health conditions there. South Korea, too, is doing its utmost by sending food, fertilisers, medicine and clothes to North Korea every year. In the wake of the recent Ryongchon train explosion in the North, the South Korean Government and people, out of great sympathy for their brethren, have actively joined hands to provide help in the recovery efforts.

Nothing is as important to mankind as leading a healthy life, free from starvation. Health and poverty reduction are the starting points for the happiness of mankind. Let us all work toward achieving this goal.

2. ADDRESS BY THE DIRECTOR-GENERAL
ALLOCUTION DU DIRECTEUR GENERAL

The PRESIDENT:

Thank you, Dr Kim Dae-jung, for a very stimulating and inspiring presentation. On behalf of the Health Assembly, I wish to thank you warmly for having honoured us with your presence.

We now suspend our consideration of item 4 of the agenda and proceed to item number 3, which is the address by Dr Lee Jong-wook.

(Applause/Applaudissements)

The DIRECTOR-GENERAL:

Thank you very much. Dr Kim Dae-jung spent altogether more than six years in prison: it affected his health and it shows.

Many of you expressed concern during and after yesterday's discussion in plenary that substantial time was being taken out of the agenda for this week. I share your concern. Some Member States expected the Secretariat to influence the process to reduce discussion; in recent years there had been prior agreement on shortening the debate on this particular item. This year, there was no such agreement. The extensive debate showed that such matters are of great importance to Member States and when Member States do not have a consensus, it is important that they hear one another. Over the coming year, I will look into ways to facilitate the smoother functioning of the Health Assembly so as to ensure that sufficient time remains for Member States to discuss during the session the entire range of topics on its agenda. Regardless of their view on the recommendation of the General Committee, I am sure all Member States share my appreciation of the steps announced by the Government of the People's Republic of China to ensure the involvement of Taiwan, China in global health. These

include the possibility of medical and health professionals from the island joining the Chinese delegation to the Health Assembly, across-the-Strait talks on the participation of Taiwan, China in relevant WHO technical activities, and working with the Secretariat to promote the participation of medical professionals from Taiwan, China in WHO's technical exchanges and technical support from WHO. The severe acute respiratory syndrome (SARS) epidemic showed us that we cannot afford any gap in our global surveillance and response network. I look forward to working in the coming months to put these proposals into action.

In the world today 2800 million people are living on less than two dollars a day; 480 million people are living in areas of conflict, fearing for their lives; 1200 million people are struggling to find clean water; 40 million women, men and children are living with HIV/AIDS; over half a million women die in childbirth every year; 1300 million people smoke, exposing themselves to illness and premature death; 1.2 million people are killed in road accidents every year. The amount of disease, suffering and death in the world can be overwhelming. There is a notorious saying that "when one person dies it is a tragedy, but when a million die it is a statistic". For those exposed to danger and suffering, it is impossible to see things this way. They cannot be indifferent. As public health ministers, officials and workers, we are constantly reminded that the statistics we use are significant because they represent individual children, women and men. It is their voices that need to be heard. I therefore invited Anastasia Kamylk from Belarus to this Health Assembly, and she will now tell us about her experience.

Ms KAMYLK (Belarus):
Г-жа Анастасия КАМЫЛК (Беларусь):

Большое спасибо, д-р Ли, за предоставленную возможность сказать несколько слов.

Добрый день, дамы и господа.

Для меня это большая честь принимать участие в Ассамблее, потому что здесь вершится история. Но в начале я вам расскажу другую историю.

В одной из стран, в одном из городов жила девушка. Она хорошо училась в школе, поступила в институт и была послушной дочерью своих родителей. Когда ей было 18, она впервые влюбилась. Это был замечательный человек. Они встречались два года, но однажды он сказал, что уезжает. "Милая моя девочка, прости меня, потому что я не могу простить себя за то, что я сделал", - сказал он и уехал.

И вскоре она попала в больницу, где к ней очень хорошо относились и почему-то жалели. "У тебя - ВИЧ", - сказал доктор 14 января 1997 года.

И это моя история. Это только одна история из миллионов тех, кто сейчас живет с ВИЧ.

Уже более семи лет я живу с ВИЧ-инфекцией и наблюдаю за процессами, которые происходят в мире. Я не перестаю задавать себе вопросы: "Почему правительство Бразилии нашло возможность и деньги на обеспечение антиретровирусной терапии для всех своих граждан, живущих с ВИЧ/СПИДом и нуждающихся в ней, а правительства других стран, особенно Восточной Европы и Центральной Азии, не могут этого сделать? Чем ценность жизни поляка отличается от ценности жизни украинца, русского, белоруса? Почему фармацевтические компании, получая миллионы от продажи антиретровирусных лекарств, не думают о том, что, снизив цены, они могут спасти миллионы жизней?"

Похоже, что человеческая жизнь превратилась в прибыльный бизнес.

Подписывая декларации о приверженности, правительства берут на себя обязательства и ответственность следовать принципам декларации. Однако реальная жизнь ВИЧ-позитивных людей мало от этого меняется.

Все также нарушаются права человека в контексте ВИЧ/СПИДа. Все также во многих странах антиретровирусное лечение недоступно. Вам известно, что, например, в Восточной Европе, Центральной Азии большинство людей, живущих с ВИЧ, – это наркопотребители. Это молодые люди в возрасте 18-35 лет. И для того чтобы лечить СПИД у этих людей, необходима заместительная терапия.

И в этом случае ценность человеческой жизни определяете вы, люди, которые наделены властью. Задумайтесь. Только одна ваша подпись, один приказ могут спасти миллионы, а могут и погубить.

До сих пор в газетах появляются статьи с такими фразами "СПИД - чума XX века", "Жертвы СПИДа", "Страшная болезнь", что формирует стигматизацию и дискриминацию по отношению к людям, живущим с ВИЧ.

А чем же ВИЧ и СПИД страшнее рака, например?

Рак развивается независимо от нашего сексуального поведения и независимо от того, потребляем мы наркотики или нет. И мы сострадаем и поддерживаем людей, больных раком. А проблема ВИЧ связана с общественной моралью, и мы отворачиваемся от тех людей, которые, по нашему мнению, ведут себя недостойно. И перестаем видеть суть проблемы. Суть проблемы - в потреблении наркотиков и незащищенном сексе. И здесь ВИЧ - это только последствия, а причины лежат глубоко в каждом человеке.

Мы уже создали множество организаций и обществ, пытающихся решить проблемы СПИДа, и сотни конференций были организованы, и множество отчетов было написано. Но к чему же мы пришли?

К тому, что за сегодняшний день, проведенный на этой Конференции, как минимум 8500 человек умрут от СПИДа. И где мы будем с вами?

Мы будем в этом красивом городе, в этом гостеприимном зале решать вопросы, касающиеся тех самых жизней, которые уносит СПИД. А, может быть, мы будем решать другие вопросы, на которые, например, вчера мы потратили четыре часа.

Сколько же еще необходимо провести встреч и конференций, чтобы люди, живущие с ВИЧ, в каждом отдельном взятом государстве стали получать полноценное лечение и стали жить без страха за завтрашний день и за свое будущее? Когда же мы перестанем считать потери?

Инициатива Всемирной организации здравоохранения "3 к 5" – это реальная возможность начать считать спасенные жизни и снизить смертность от СПИДа.

Я верю, что здесь собрались как раз именно те люди, которые отвечают как за свои слова, так и за свои действия.

Ведь именно от вашего решения зависит судьба отдельно взятого человека. Если даже он живет с ВИЧ.

Только на минуту представьте себе, что вам сказали, что у вас ВИЧ. Только на одну минуту. Я помню эти минуты.

Страх, обреченность и безысходность - это те чувства, которые поглотили меня. Что будет дальше? Смогу ли я родить ребенка? Как сказать об этом своим любимым людям? Неужели это конец?

Желание остаться одной и забиться в угол заставило меня выбежать из кабинета.

Это сейчас я знаю, что с ВИЧ можно жить полноценно. Это сейчас, повстречав за семь лет много ВИЧ-позитивных, которые принимают терапию, я понимаю, что лекарства действительно вытаскивают человека из могилы. Я знаю, что могу любить. Создать семью. Родить ребенка. Но также у меня до сих пор есть страх, что в будущем в нужный момент я не смогу получить то, что спасет жизнь мне или моему будущему ребенку.

Каждый человек достоин того, чтобы ему была оказана своевременная медицинская помощь. И каждый человек имеет право ее получить. Будь это ВИЧ/СПИД или любое другое заболевание. И врач в больнице должен иметь все лекарства, оборудование и материалы, чтобы оказать эту помощь и не нарушать права человека и закон.

Сейчас в зале сидит очень много людей, принимающих решения в своем государстве и наделенных властью.

Я обращаюсь к вам. Помните - это ваша большая ответственность и ваш долг - действовать на благо ваших граждан.

И дай Бог, чтобы ваши решения сохранили достоинство и права каждого человека. Даже если этот человек живет с ВИЧ.

Спасибо.

The DIRECTOR-GENERAL:

Thank you, Anastasia, for your courage, and for giving such a clear and specific reminder of the responsibilities of those taking part in this Health Assembly.

Advances in technology have profoundly changed the ways in which we live and work. They have brought many improvements, but our capacity to enhance health is matched by our capacity to damage it. The gap between rich and poor has widened and, in spite of surpluses, hunger and thirst remain widespread. Despite commitments of nations to preserve harmony, peace and security, hundreds of millions are affected on a daily basis by wars and conflicts. Through our Health Action in Crises programme, WHO is active in most areas of the world affected by armed conflict. I would like to use this opportunity to reassert that WHO is entirely opposed to any action that exploits health facilities, vehicles or personnel in war or conflict zones. Equally, attacks on health workers have to be stopped. International humanitarian law imposes obligations on all combatants to protect civilians' access to basic needs – water, sanitation, food, and functioning health facilities. We see more and more examples of civilians being made the victims of conflicts which often continue for many years. It is the people who can no longer get food, clean water and health care who suffer most, particularly women, children, older people, and those with chronic conditions. Health agencies have to stand up for those whose lives and health are endangered in this way.

There are also many parts of the world in which major environmental problems cause health to suffer as a result of unsafe water and unsafe living conditions. These are often related to unplanned urbanization, climate change and uncontrolled development. Even in areas not afflicted by these health hazards, preventable chronic diseases related to lifestyle severely limit individual and public health. Nevertheless, there is evidence that the world's desire and capacity to solve these problems is increasing. Adoption of the Millennium Development Goals in 2000 demonstrated that the global community was serious about the need to reduce poverty and protect health. The most damaging inadequacy of today's health systems is their inequity, both within countries and between them. Hopes of peace and security in the world fade where these inequities prevail. Adequate health services are not only essential for the three Millennium Development Goals that relate specifically to health, but make major contributions to the other five as well.

The increase in development assistance for health over the last few years is also a welcome sign. This went up by an average of US$ 1700 million a year between 1997 and 2002. Much of this increase was the result of a growing awareness of the devastation being caused by HIV/AIDS. In some communities, close to half the young adults are infected with HIV. They will die in the next few years unless they receive effective treatment. In December of last year, on World AIDS Day, WHO launched the strategy to accelerate access to antiretroviral treatment. The initial objective is to work within a broad alliance of partners to get three million people in developing countries on to treatment by the end of 2005. We are working with the health services in countries to achieve this, following a double imperative: there must be universal access to treatment by the earliest possible date, and ever more effective approaches to prevention. With the help of our partners we have developed simplified treatment approaches and prequalified fixed-dose drug combinations of antiretroviral drugs. We will further develop and expand this work. I also welcome the announcement made earlier this week by the Government of the United States of America about a proposed rapid process for review of fixed-dose combinations and co-packaged products. In March, the Government of Mozambique issued a compulsory licence for manufacturing a triple combination of antiretroviral drugs to meet national needs. In doing so, it became the first African country to take this important step in implementing the Doha Declaration on the TRIPS Agreement and Public Health. Canada was the first country to propose changes to its patent legislation to put into practice a decision made by WTO in August 2003, allowing export of generic medicines to countries with insufficient pharmaceutical manufacturing capacity. I welcome the announcement made last week that this legislation has been adopted.

(Applause/Applaudissements)

The target for the Millennium Development Goal for HIV/AIDS is to stop the spread of HIV and begin its reverse by 2015. The impact of treatment on prevention of new HIV infections is not yet

fully known, but if, for each person receiving treatment, just one new infection is averted, the "3 by 5" initiative will significantly speed up the achievement of the target for the Millennium Development Goal for HIV/AIDS. The demand is clear. During February and March, WHO sent additional staff to 25 countries to assist in making national plans of action and applications for grants from The Global Fund to Fight AIDS, Tuberculosis and Malaria. Over 90% of the countries we are working with have stated that they need expert help in capacity building and training; 60% need help with drug procurement and supply chain management; and 50% need help with monitoring and evaluation. We are responding to these requests. An unprecedented amount of political will and financial resources is now focused on the fight against HIV/AIDS, tuberculosis and malaria, particularly through The Global Fund and other multilateral and bilateral support.

Last week, the Prime Minister of Canada announced a grant of 100 million Canadian dollars to support our work on the "3 by 5" initiative. Together with the earlier funds provided by the Government of the United Kingdom of Great Britain and Northern Ireland, this will enable us to rapidly accelerate our support to countries for scaling up access to treatment. Thank you, Canada. We will make our first detailed progress report on the "3 by 5" initiative to the XV International AIDS Conference in Bangkok in July. In the meantime, this year's world health report, entitled "Changing history", explains how we are now in a position to save the lives of millions of people from HIV/AIDS, and why we must seize this opportunity.

Viruses are unpredictable and they have no respect for national boundaries. There is, as yet, no way to say whether SARS has finally been brought under control, or whether avian influenza will make a comeback in Asia or other places. Since the SARS epidemic was contained last July, there have been four further outbreaks in Asia. Three of these arose from laboratory accidents, emphasizing the need to strengthen biosafety. In January, there was an historically-unprecedented outbreak of avian influenza in eight Asian countries, with 34 human cases and 23 deaths. WHO experts provided prompt support for the authorities to contain these epidemics. Their combined efforts have been successful so far, but sustained vigilance is required.

Our other long-term disease control programmes include poliomyelitis eradication. Here, the key to success will be tenacity, both in our colleagues running the immunization campaigns and maintaining surveillance, and in our donors. We are on the verge of eradication, with just 22 cases to date this year in all of Afghanistan, Egypt, India and Pakistan. On the other hand, we have had setbacks in west and central Africa, with an explosive outbreak that has paralyzed over 500 children. The leaders in these areas have now planned to restart synchronized mass immunization campaigns across 22 countries. If we do not lose our nerve in these last stages of the campaign, where so much can be either lost or gained, we will soon have kept the pledge made by the Health Assembly in 1988, to eradicate poliomyelitis.

The Framework Convention on Tobacco Control, adopted by the Health Assembly one year ago, has now been signed by 112 countries plus the European Union, and ratified by 14. When 40 countries have ratified it, the Convention will come into force and further help governments and health authorities to protect the public from one of today's most serious and most unnecessary health hazards.

I believe we continue to improve our capacity as an organization to respond to the challenges facing us. Last year, at the Health Assembly, in addition to my pledge to close the treatment gap for people living with HIV/AIDS, I made specific commitments in four other areas, designed to enhance our effectiveness in countries. I set specific targets for decentralization. Since then, we have increased the budget allocation to regional and country offices for the current biennium to 70%. I recognized the need to improve efficiency. We have developed a strategic framework for general management and launched initiatives to promote collaboration, strengthening financial management and streamlining work processes. I committed myself to improving our accountability. I am pleased to report that a draft of the performance assessment report for the 2002-2003 biennium is already available. With results-based budgeting, we are now reporting on our achievements against expected results. The development of this report has also assisted us in planning for the next biennium. I stressed the need to improve our staffing situation by promoting greater equity in gender and geographical representation, and promoting mobility and career development, to get better results in countries. We continue to make progress in these areas and a mobility and rotation scheme was launched last month. I am also

pleased to announce that the Bill & Melinda Gates Foundation has committed funding for the Health Leadership Service. This new initiative will provide a two-year structured learning experience in WHO for young health professionals, primarily from unrepresented and under-represented developing countries.

But I would also like to highlight four areas of health work in which we need to do more. We have yet to get to grips with the links between health, equity and development. The underlying theme of my first year as Director-General is equity and social justice. To support our work in this area, I am setting up a new commission to gather evidence on the social and environmental causes of health inequities, and how to overcome them. The aim is to bring together the knowledge of experts, especially those with practical experience of tackling these problems. This can provide guidance for all our programmes. We have yet to make significant progress in reducing maternal deaths and protecting the health of children. I am, therefore, making this a major priority for the coming year. The world health report and World Health Day 2005 will share a common theme: the health of women and children. This will bring together a large number of WHO's activities and those of our partners, particularly immunization, safe motherhood, and nutrition. We have yet to reduce substantially the gross inequity in health research funding. Every year, more than US$ 70 000 million are spent on health research and development by the public and private sectors. Yet less than 10% of this is used for research into 90% of the world's health problems. We are cosponsoring, with the Government of Mexico, a ministerial summit on health research in November. The summit will examine this issue, and focus on the knowledge and action needed to achieve the Millennium Development Goals.

Finally, we still have gaps and delays in health information systems. We have therefore set up a Strategic Health Information Centre at WHO headquarters. I inaugurated it the other day with the United States Secretary of Health and Human Services who supported this financially and also technically. It consists of the most rapid and powerful information and communication facilities currently available for the management of crises and outbreaks. This technology will enable individuals, teams and Member States to take more effective action in emergencies. The Centre will also provide ongoing support for information management and dissemination. At the technical level, it is important to be sure that there is no hole in WHO's Global Outbreak Alert and Response Network.

(The speaker continued in French.)
(L'orateur poursuit en français.)

Monsieur le Président,

L'ordre du jour de cette Cinquante-Septième Assemblée mondiale de la Santé témoigne du souci que nous partageons tous de nous atteler aux principaux problèmes de santé qui se posent aujourd'hui dans le monde. Vous traiterez des stratégies mondiales destinées à promouvoir une bonne alimentation et l'exercice physique, et à améliorer la santé génésique. Les tables rondes feront porter votre attention sur les mesures à prendre pour limiter les effets de la pandémie de VIH/SIDA. Les réunions d'information techniques vous renseigneront sur nos récentes activités dans les situations de crise et dans le domaine de la santé mentale. Ce ne sont là que quelques-uns des nombreux thèmes importants sur lesquels vous vous pencherez cette semaine. Il incombe à cette Assemblée mondiale de la Santé d'inciter le monde à agir en faveur de la santé, et c'est là une grande responsabilité. Les délibérations, et les décisions qui seront prises ces six prochains jours, pourront avoir une influence profonde sur la santé de chacun, partout dans le monde.

J'ai commencé par des chiffres. Pour terminer, j'en citerai d'autres : les cinq millions d'enfants qui, sinon, seraient paralysés, mais qui marcheront en 2005 grâce à l'action menée pour éradiquer la poliomyélite ; les trois millions de tuberculeux désormais soignés chaque année par la stratégie DOTS ; les six cent mille cas de cécité évités grâce au Programme de lutte contre l'onchocercose. La principale différence est que ces derniers chiffres reflètent les résultats que cette Organisation est capable d'obtenir. Ils sont porteurs d'espoir. Espoir pour des personnes comme Anastasia et comme les millions de personnes qui vivent avec le VIH.

Monsieur le Président, Mesdames et Messieurs les Ministres, Mesdames et Messieurs les délégués, Mesdames et Messieurs, les membres du personnel de cette Organisation partagent votre

volonté d'améliorer la santé dans le monde, et nous sommes résolus à continuer de servir ceux dont les besoins dans ce domaine sont les plus grands. Je vous remercie.

(Applause/Applaudissements)

3. REPORTS OF THE EXECUTIVE BOARD ON ITS 112TH AND 113TH SESSIONS RAPPORTS DU CONSEIL EXECUTIF SUR SES CENT DOUZIEME ET CENT TREIZIEME SESSIONS

The PRESIDENT:

I now proceed to item 2 of the agenda, "Reports of the Executive Board on its 112th and 113th sessions". I have the pleasure of giving the floor to Dr Afriyie, Chairman of the Board.

Dr AFRIYIE (Chairman of the Executive Board):

I would like to focus briefly on the highlights of the work of the Executive Board over the past year, at its 112th and 113th sessions. A more detailed report is contained in document A57/2. Before doing so, it is with great sadness that I have to inform you that Professor Dang Duc Trach of Viet Nam, a member of the Executive Board, passed away in April this year.

At its 112th session the Board amended its Rules of Procedure as proposed by the Ad hoc open-ended intergovernmental working group to review the working methods of the Executive Board. The 113th session in January was the first Board session to be convened under the revised Rules. At the 113th session of the Board, some of the main topics and issues discussed by the members under technical and health matters included the Director-General's report, HIV/AIDS and the revision of the International Health Regulations. On the revision of the International Health Regulations, the Board agreed to the proposed timetable for a series of regular meetings in March-June this year, the outcome of which will be consolidated into a revised draft review. All Member States will then meet at a working group to be held in the first part of November this year. The outcome of the process will be reported to the Board and the Health Assembly next year. The Board considered reports on the quality and safety of medicines (including brand products) and the WHO medicines strategy; strengthening health systems, particularly for primary health care; and the influence of poverty on health. Members noted information on the epidemic of SARS, including an update on the recent outbreak of avian influenza, and welcomed the WHO-UNICEF strategic plan for, and progress in, reducing measles mortality. There was also an update on progress in the eradication of poliomyelitis in the six countries remaining endemic for the disease. The Board further noted reports on progress in the work on patient safety and protecting, promoting and supporting appropriate infant and young child nutrition. Resolutions have been put forward by the Board for consideration by the Health Assembly on surveillance and control of Buruli ulcer, health promotion and healthy lifestyles, road safety and health, genomics and world health, human organ and tissue transplantation, control of human African trypanosomiasis, a draft global strategy on diet, physical activity and health, a draft strategy on reproductive health, and family and health.

Under programme and budget matters the Board's discussion included progress on the programme budget 2004-2005 and regular budget allocations to regions. Members also noted the report on the status of collection of assessed contributions. The Executive Board appointed Dr Samlee Plianbangchang as Regional Director for South-East Asia and expressed its appreciation to the retiring Regional Director, Dr Uton Muchtar Rafei. Dr Shigeru Omi was reappointed as Regional Director for the Western Pacific. With regard to staffing matters, the Board noted the recruitment strategy integrating gender and geographical balance with its proposed plan of action for implementation.

The Board also noted the reports of the Programme Development Committee, the Administration, Budget and Finance Committee and the Audit Committee as part of the review of these working matters. The Board reviewed its committee system; members agreed in principle to merge these three committees into one single committee and requested that draft terms of reference and options for membership should be prepared for consideration by the Board at its 114th session.

In November an informal retreat of Executive Board members was held in Accra, Ghana. Members were able to have a frank and open exchange of views with the Director-General and his senior staff on a variety of issues, such as the Millennium Development Goals and health targets, partnerships, country focus, and financing of WHO. My colleagues and I will be available during the discussions in the Committees of the Health Assembly. We stand ready to lend our full support and provide information as needed on how the Board dealt with certain items under consideration by the Health Assembly.

The PRESIDENT:

I should like to take this opportunity to pay tribute to the work of the Executive Board, and in particular to express our appreciation and our warm thanks to the outgoing members who have contributed very actively to the work of the Board.

This concludes our review of item 2 of our agenda.

4. ADDRESS BY THE DIRECTOR-GENERAL (resumed)
ALLOCUTION DU DIRECTEUR GENERAL (suite)

The PRESIDENT:

We shall now resume consideration of item 3.

Before starting, I would recall delegates' attention to the Executive Board recommendation that statements should give special attention to the theme of HIV/AIDS. Delegates wishing to report on salient aspects of their health activities could make such reports in writing for inclusion in the record, as provided in resolution WHA20.2. I would like to also draw your attention to resolution WHA50.18 recommending that delegates should limit their statements to five minutes. The list of speakers is published in the Journal, and I should ask if any delegation wishes to withdraw from the list to advise the Secretariat.

Should a delegate wish to submit – in order to save time – a prepared statement for inclusion in extenso in the verbatim records (which is permissible to do on this agenda item 3 only), or whenever a written text exists of a speech which a delegate intends to deliver, copies should be handed to the officer responsible for the list of speakers in order to facilitate the interpretation and transcription of the proceedings. This procedure would also apply to those delegates who have to leave Geneva and are not able to deliver their speech under this agenda item before they leave. They can ask for their text to be published in the records of the Assembly.

The debate on item 3 is now open.

Mr MARTIN (Ireland):

It was a particular privilege for me to have witnessed the inspiring words of former President Kim Dae-jung, in particular his emphasis and focus on poverty and the needs of children in the developing world.

I have the honour to speak on behalf of the European Union. The candidate countries Bulgaria, Romania and Turkey, and the countries of the stabilization and association process and potential European Union candidates Albania, Bosnia and Herzegovina, Croatia, Serbia and Montenegro, The former Yugoslav Republic of Macedonia align themselves with this statement. May I also warmly congratulate Dr Lee on this, his first Health Assembly as Director-General. On 1 May Ireland was privileged to host a day of welcomes in Dublin to mark the accession to the European Union of 10 new partners. We look forward to working together in Europe and, within the global structure of the World Health Organization, to promoting harmonious development of programmes with our many partners across the globe. The World Health Organization belongs to us all, and we share the responsibility of ensuring that it is vibrant and dynamic.

We thank Dr Lee for his very comprehensive and inspiring address. WHO and its Member States face many challenges but, as the Director-General has said on a previous occasion, the health of all people remains the guiding rationale for all of our activities. The European Union notes the Director-General's comments on the HIV/AIDS crisis. The priority accorded by WHO to HIV/AIDS is commendable, given the exceptional nature of the crisis. The European Union is encouraged by the leadership shown by WHO in the global response to HIV/AIDS in the health sector. Far from coming under control, HIV/AIDS is spreading rapidly in many parts of the world and now poses a global threat affecting all regions. The fastest growing rate of new infections is now in countries in eastern Europe and central Asia. The conference "Breaking the Barriers: Partnership to fight HIV/AIDS in Europe and Central Asia", held in Dublin in February 2004, played an important role in raising awareness and building political leadership and commitment in these countries. Indeed, we were privileged to hear Anastasia from Belarus speak at that Conference also, and she sent us yet again today a very clear message and a call to action. This is particularly important as the creation of The Global Fund to Fight AIDS, Tuberculosis and Malaria has made it possible to mobilize additional resources for the fight against the three killer diseases.

The European Union endorses the statement contained in the Secretariat's report on HIV/AIDS (document A57/4) that antiretroviral treatment must be accompanied by renewed and vigorous efforts to promote and accelerate effective preventive strategies. The advent of effective and affordable treatment for HIV in no way lessens the importance of prevention as the basis of national responses to HIV/AIDS. On the contrary, WHO as an organization and all its Member States together share a responsibility to ensure that a balanced approach between prevention, treatment, care and mitigation is upheld. The primary task before us is, in fact, to stop HIV/AIDS from spreading any further.

A coordinated response to HIV/AIDS is one of the greatest challenges we face today. The "Three Ones" launched recently by UNAIDS constitute an important development and should be accepted as the guiding principles for all international initiatives to support national AIDS responses. This increases donor harmonization, accommodates different approaches within a nationally-led response and gives the best chance of achieving results. Related to this, the treatment of AIDS and other responses to HIV/AIDS should be planned and implemented within the framework of national development plans. The leadership of WHO and UNAIDS is needed at global level and country level to facilitate a harmonized approach and ensure that HIV/AIDS strategies are coherent. The launch of the "3 by 5" initiative by WHO in December 2003 was an important milestone in the global fight against HIV/AIDS. Access to antiretroviral therapy is one of the core components of an effective health sector response to HIV/AIDS. The global response and commitment to provision of antiretroviral therapy is welcome. This commitment must be sustained since this treatment is a lifelong measure. AIDS will need to be treated as a chronic problem, with all the health systems and psychosocial support that this will require. Much effort is needed to ensure that treatment is provided in an equitable, gender-sensitive and poverty-focused manner.

The European Union welcomes the attention given in *The world health report 2004: Changing history* to health systems in the context of the HIV/AIDS treatment initiative. It is essential that "3 by 5" and other global initiatives for treatment of HIV/AIDS help to strengthen health services at country level. The crisis of human resources in developing countries has been exacerbated by HIV/AIDS. Scaling up of care and treatment adds a further burden of responsibility on over-stretched staff. It is therefore important that the right of access to effective treatment for HIV/AIDS should not be at the expense of other poverty-focused essential health-care services. There needs to be good collaboration among the different components of health services. Special emphasis should be placed on strengthening sexual and reproductive health services which are crucial in HIV/AIDS prevention and an essential part of a comprehensive health sector response to HIV/AIDS. WHO country offices should become more involved in this sector-wide challenge. With the "3 by 5" initiative we have set ourselves an unprecedented challenge with a very short time frame. It is imperative that we learn from experience, develop models of good practice and share lessons with other countries. WHO has a key role to play in this regard. The European Union looks forward to receiving further progress reports from the Director-General on HIV/AIDS, both at the Executive Board and Health Assembly meetings. In this regard the European Union also welcomes WHO's draft strategy on reproductive health which is being presented for endorsement by this Health Assembly.

The European Union respects the technical expertise of WHO across a broad range of issues, from which we have benefited for many years. A recent example is the collaboration between Member States and WHO in the matter of avian influenza, an item which will be discussed by the Executive Board next week. European Union health ministers appreciated the attendance of the Director-General at an informal meeting which was held in February to exchange views on the matter. Concerns for the spread of avian influenza and the recent reappearance of the SARS virus reminds us once again of the need for vigilance in the prevention and control of communicable diseases. In response to this need, the European Commission launched a special research call to tackle SARS last summer and, for your information, there will be eight research consortia with European and Chinese partners active in this field. The European Community is now at the implementation stage of establishing the European Centre for Disease Prevention and Control, which will be located in Sweden. The European Commission has recently completed the preparation of a Pandemic Preparedness Plan.

The European Community is currently considering the text of the International Health Regulations in detail, which has included discussion with officials of WHO. The European regional consultations which will take place in Copenhagen in June will afford an opportunity for a full exchange of views within the greater European area. At this stage, the European Community recognizes the intent of the draft Regulations. The European Community will play its full part in the global efforts to achieve the ambitious target of adoption of the revised International Health Regulations at the Fifty-eighth World Health Assembly. The Director-General reminded us at the Executive Board in January that global cooperation is also indispensable for noncommunicable disease prevention. The strategy for noncommunicable diseases was presented to the Health Assembly four years ago. It focuses on three major risk behavioural factors: tobacco use, unhealthy diet and physical inactivity. The European Union has played its full part in arrangements for the adoption of the WHO Framework Convention on Tobacco Control and places equal emphasis on the early ratification and entry into force of the Framework Convention. We now have the opportunity, at this Health Assembly, to take a further step in relation to tackling noncommunicable diseases by approving the draft global strategy on diet, physical activity and health. The European Union recognizes fully the need for endorsing a strategy which will support and enable Member States to develop action plans appropriate to national circumstances. The European Union also supports the draft resolution on health promotion and healthy lifestyles, which draws on *The world health report 2002*, and which calls on Member States to strengthen capacity for implementing comprehensive and multisectoral health promotion policies and programmes, with particular attention to poor and marginalized groups.

The European Union welcomes the WHO/World Bank *World report on road traffic injury prevention* which was launched on World Health Day. It provides a timely commentary on road safety against a background of 1.2 million deaths and 50 million injuries on our roads. The European Union notes the adoption of United Nations General Assembly Resolution 58/289, which invites WHO to act as a coordinator on road safety issues within the United Nations system and encourages the Organization to collaborate with United Nations regional commissions in this area. Our health is determined to a considerable extent by our environment. The European Union is pleased to be associated with WHO in the Fourth Ministerial Conference on Environment and Health, which will take place next month in Budapest. The Conference will address a range of issues which affect children, including childhood respiratory diseases and childhood asthma. We particularly welcome moves to prepare a children's environment and health action plan for Europe.

Finally, the European Union wishes to endorse the draft resolution on human tissue and organ transplantation. This is the result of work carried out by an international group of experts during a preparatory meeting held in Madrid. In this context, the European Union recognizes the importance of increased efforts to confront the challenge of organ trafficking on the global level. On behalf of the European Union I wish to assure the Director-General that we are ready to support him in the year ahead in addressing the various tasks which he has outlined and in the pursuit of higher standards of public health.

The PRESIDENT:

I now give the floor to the delegate of Qatar, who speaks on behalf of the Gulf Cooperation Council – that is, Bahrain, Kuwait, Oman, Saudi Arabia, United Arab Emirates, Yemen and his own country, Qatar.

Dr AL-BINALI (Qatar):

الدكتور حجر أحمد حجر البنعلي (قطر):

بسم الله الرحمن الرحيم،

معالي الرئيس، معالي المدير العام، أصحاب المعالي والسعادة رؤساء وأعضاء الوفود أيها الحفل الكريم، السلام عليكم ورحمة الله وبركاته.

يسعدني أن أتحدث إليكم من هذا المنبر باسم مجلس وزراء الصحة لدول مجلس التعاون لدول الخليج العربية دولة الإمارات العربية المتحدة، مملكة البحرين، المملكة العربية السعودية، سلطة عُمان، دولة قطر، دولة الكويت، والجمهورية اليمنية.

كما يسرني أن أتقدم لكم – معالي الرئيس – بالأصالة عن نفسي ونيابة عن زملائي رؤساء وفود دول مجلس التعاون لدول الخليج العربية، بالتهنئة على انتخابكم رئيساً كما أهنئ مساعديكم نواب الرئيس ورؤساء اللجان الرئيسية.

معالي الرئيس، لقد تميز العقد الأخير من القرن الماضي بعدد من النتائج المترتبة على التحولات السياسية والاقتصادية الهائلة التي أثرت بلا شك على الهياكل التنظيمية لمؤسسات الدول الأعضاء. إلا أن منظمة الصحة العالمية انتهجت فلسفة رشيدة نحو تحقيق الصحة كمطلب إنساني نبيل، واتخاذ الصحة جسراً للسلام بين الدول والشعوب.

حضرات السادة والسيدات، إن مجلس وزراء الصحة لدول مجلس التعاون لدول الخليج العربية منظمة إقليمية فنية متخصصة، تتمتع بشخصية اعتبارية وتعمل على تحقق التعاون والتكامل بين دول المجلس في المجالات الصحية. ويهدف المجلس إلى توحيد جهود هذه الدول من أجل تنمية الخدمات الصحية وتوفير أعلى مستوى من الصحة للمواطنين.

ولقد استطاع المجلس خلال ربع قرن أن يحّول العديد من أهدافه الاستراتيجية وتوجيهاته التطويرية وبرامجه التنموية إلى أعمال فاعلة ناجحة في مختلف مجالات العمل الصحي.

ولقد حرص هذا المجلس على العمل بالالتزام الكامل ضمن إطار منظمة الصحة العالمية وتوجيهاتها، مما أسهم في استكمال المتطلبات الأساسية وتوفير البنية التحتية الصحية، وإرساء النظم الصحية، وتنمية الموارد البشرية لذلك الغرض.

لقد أدى التعاون المثمر والبنّاء مع المكتب الإقليمي لمنظمة الصحة العالمية لشرق المتوسط إلى تجويد الخدمات الصحية والارتقاء بنوعية الأداء إلى مستويات متميزة في مجالات عديدة وبرامج مستحدثة مثل الجودة الصحية، والطب المبني على الأدلة والبراهين، وتطوير النظم الصحية، ومكافحة الأمراض المعدية وغيرها. وأثمرت هذه العلاقة الوطيدة عن تنظيم العديد من حلقات العمل الإقليمية خلال العام الماضي.

ودول مجلس التعاون جزء لا يتجزأ من المنظومة العالمية تؤثر وتتأثر بما يدور حولها، لذلك انتشر فيها كغيرها من الدول العديد من أنماط الحياة غير الصحية، فأعقب ذلك زيادة غير مسبوقة في الأمراض المزمنة الناتجة عن تغيّر أساليب الحياة. وسرعان ما سارعت دول المنطقة بالانضمام إلى الشبكة الإقليمية لشرق المتوسط حيث يجري حالياً الانتهاء من إعداد خطة عمل متكاملة وفق جدول زمني محدد لمواجهة العديد من الأخطار المنتشرة بنسب عالية مثل التدخين، وارتفاع الضغط ، والسمنة، وقلة الحركة، وغيرها من المشكلات الصحية.

وتجدر الإشارة أن حملة مكافحة التدخين التي تتبناها المنظمة بنجاح والتي تُوّجَت بإقرار الاتفاقية الإطارية لمكافحة التبغ في الجمعية العمومية الماضية حيث أشيد بهذا القرار الحكيم والذي وقعت عليه معظم دول المجلس.

أيها السيدات والسادة، إن استعمال القوة المفرطة والقصف المدني في المناطق المحتلة من فلسطين والعراق وغيرهما من أنحاء العالم له آثاره السلبية على الصحة الجسمية والنفسية، وهو مخالف للقوانين الدولية والأخلاق البشرية لحقوق الإنسان، مما يتسبب في إيجاد أجيال من المعاقين ويحمّل ذلك المجتمعات المنكوبة بالاحتلال عبئاً مادياً واجتماعياً ونفسياً كبيراً.

إن الأوضاع العالمية المتصارعة والمتلاحقة والتي أولتها المنظمة اهتماماً بالغاً وخصوصاً طب الطوارئ والكوارث، ذهبت بنا إلى التفكير في إطلاق شعار "الأمن الصحي العالمي" كحق من حقوق الإنسان لأن آلاف الضحايا تسقط كل عام نتيجة الحروب والكوارث، مما يدعو إلى إعادة النظر في إمكانية تشكيل فريق صحي ومستشفيات متنقلة لتحقيق الأمن الصحي تحت مظلة منظمة الصحة العالمية.

معالي الرئيس، حضرات المندوبين الموقرين، لقد تحقق الكثير من الإنجازات التنسيقية والتنفيذية. ولكن مازال الطريق أمام منظمة الصحة العالمية طويلاً وشاقاً للوصول إلى الهدف الإنساني النبيل وهو "توفير الصحة للجميع" كما أن التحديات المطلوب مواجهتها هائلة تتطلب حشد المزيد من الموارد وتكثيف الجهود على كافة المستويات الوطنية والإقليمية والدولية ضمن نظام صحي متكامل ومرتكز على الرعاية الصحية الأولية.

ولا يفوتني، في هذا المقام، أن أعرب عن تأييدي لسعادة الدكتور لي لاعتزامه تركيز ٧٥٪ من الموارد البشرية والمالية للمنظمة للعمل على الصعيدين القطري والإقليمي، مما يعني إيلاء المزيد من الاهتمام لعمل المنظمة، ويؤكد حدوث تحول تنسيقي ملموس في دوائر الاهتمام وتخصيص المزيد من الأموال لدول الأقاليم المحتاجة إلى تطوير خدماتها الصحية. وكلنا أمل أن يؤدي ذلك إلى توزيع الميزانية توزيعاً يتسم بالإنصاف، ومن ثم إحراز التقدم نحو تلبية الاحتياجات الصحية لجميع أفراد المجتمع في عالم يعاني من مشكلات صحية ضخمة تتطلب بذل المزيد من الجهود على كافة المستويات لإيجاد أفضل السبل لحلها.

وفي الختام أتوجه إليكم بالشكر الجزيل على حسن إصغائكم متمنياً لكم جميعاً التوفيق والسداد. والسلام عليكم ورحمة الله وبركاته.

Dr GERBERDING (United States of America):

I am not the Secretary of Health and Human Services, Mr Tommy Thompson, but I am very honoured to be here on his behalf.

On behalf of President George Bush, I would like to reaffirm the commitment of the United States of America to the World Health Organization. Our Secretary has been coming to this meeting for four years now and has visited 35 countries, some more than once. He has been so impressed with your leadership, your commitment and your passion for the incredible work that you do. The international community has joined together in so many ways to advance the health and well-being of people all around the world. One of the most significant initiatives has been the WHO Framework Convention on Tobacco Control and I am very pleased to announce that, on Monday, Mr Thompson signed the Framework Convention on behalf of the United States.

Mr Thompson is also pleased with our collective efforts in the global fight against HIV and AIDS. President Bush's five-year US$ 15 billion emergency plan for AIDS relief is the largest commitment ever made by a single government toward an international health initiative. Through this initiative, we seek to provide treatment to two million people living with HIV, to provide care to 10 million people who are infected or affected by HIV, including vulnerable children, and we aim most importantly to prevent seven million new HIV infections. To help achieve these goals, President Bush's global AIDS coordinator, Ambassador Randall Tobias, and the Secretary announced on Sunday a new procedure to fast-track approval of drugs by the United States Food and Drug Administration. This approval will apply to fixed-dose combination drugs and blister packs from both innovator and generic companies so that we can purchase them with confidence for the emergency plan. As Chairman of the Board of Directors of The Global Fund to Fight AIDS, Tuberculosis and

Malaria, Mr Thompson is very pleased by The Fund's work. The Fund has already approved 224 grant programmes in 121 countries that total more than US$ 2 billion. The United States of America has pledged US$ 1.97 billion to The Fund through 2008. We can and we will stop the AIDS pandemic because we have the will, the means and – most importantly – the passion to do so.

The Fifty-seventh World Health Assembly will be remembered for its work on diet and physical activity. In the United States chronic illnesses cause seven out of ten deaths. In 2000, poor diet and physical inactivity which contribute to obesity, cancer, heart disease and diabetes, accounted for 400 000 actual deaths in the United States alone. Only tobacco causes more preventable deaths. America spends US$ 1.5 trillion on health care each year. Seventy-five per cent of those dollars are spent treating chronic diseases. If Americans had practised healthier habits they could have saved a great deal of money and could have spent that money on many priorities other than health. The good news is that it does not have to be this way. Diet, physical activity, health screening and avoiding risky behaviours can prevent cancer, diabetes, heart disease and many of the other leading causes of death and disability. This applies to developed and developing countries. People who eat right, exercise and get health screenings, enjoy greater health and happiness well into their senior years. The WHO draft global strategy on diet, physical activity and health serves as a sound blueprint for action for all of us but there is no time to lose. As Mr Thompson would say, our waistlines are expanding while our health is deteriorating. The time for action is now.

The Global Polio Eradication Initiative is nearing the end of a long campaign. In April the Secretary of Health and Human Services visited Afghanistan, India and Pakistan and immunized children against poliomyelitis. This effort is a model of private-public cooperation in pursuit of a humanitarian goal. The United States Government, in partnership with the World Health Organization, UNICEF, The Rotary Foundation and many others, has played a leading role in this initiative.

Today we stand on the brink of a great victory. For only the second time in the history of the world we are in a position to completely eliminate a disease from this planet. We are committed to staying the course. We will succeed if we resolve to finish this job together. We also remain committed to working with member governments and the World Health Organization to develop and support the Global Outbreak Alert and Response Network, to support stronger surveillance for rapid detection, for shared information systems and many other more effective communication channels.

On behalf of Mr Thompson, I specifically thank the Director-General for his leadership in establishing the new WHO strategic health information centre which is open for your viewing this week. The Department of Health and Human Services helped design and furnish this resource and it will prove to be a remarkable facility in times of public health emergency.

The recent outbreak of avian influenza throughout Asia is unprecedented and it reminds us just how much more work we have to do before we are prepared nationally and internationally. We need to work together to combat these infections. We need to strengthen our influenza surveillance reporting and control capabilities. Last year Mr Thompson spoke about the global threat of SARS. Our diligence has prevented a repeat of the SARS epidemic and this year we managed to deal with avian influenza effectively. Undoubtedly this will not be the last time that the world will have a health threat that requires global and regional coordination. If we are really serious about stopping disease outbreaks in their tracks, we cannot ignore the millions of people who are at risk. That is why the United States has strongly supported Taiwan's inclusion in efforts against SARS, avian influenza, and the process to revise the International Health Regulations. Public health knows no borders. Let us never forget that our common agenda for health transcends governments, cultures, language, and politics. We can accomplish so much more by working together. Again, on behalf of the United States Government, I would like to thank you for your leadership and compassion, but most of all for your friendship.

Mrs SUDARAT KEYURAPHAN (Thailand):

My sincere congratulations and heartfelt appreciation go to the Director-General, Dr Lee Jong-wook, for his inspirational vision, action and hard work, as well as exceptional leadership that have guided the World Health Organization from the start of his tenure.

This year's World Health Day theme, "Road safety is no accident", is exceptionally relevant and challenging. In Thailand, the strong campaign for prevention of road accidents started in 1995. Now it

has become the national agenda of top priority. A multisectoral approach is used to incorporate resources from different ministries and sectors, both public and private. Many laws have been enacted, for example, on the use of safety belts and the control of blood alcohol level. Moreover, emergency care centres and services have been upgraded in 22 major provinces in Thailand and we will achieve nationwide coverage next year.

The issue of HIV/AIDS chosen by the Executive Board as this year's theme is without doubt timely and highly appropriate. I would like to take this opportunity to commend the Director-General for putting forward the target of "3 by 5" right from the beginning of his term. Please be assured of Thailand's full support for this commitment. The first case of AIDS in Thailand was reported in September 1984. It was speculated that Thailand would face a dreadful rising trend of this pandemic in the decades that followed. Indeed, the incidence of HIV infections increased at an alarming rate and peaked at more than 100 000 new infections each year during 1990-1992. The Thai Government, with its serious commitment and strong support from all parts of society, then invested heavily in prevention strategies nationwide. Many campaigns, especially on prevention and control measures, were carried out on a regular basis. The result of these collective efforts turned out to be very encouraging. Since 1993, the incidence of HIV/AIDS infections has continuously shown a declining trend. New infected cases have been reduced to less than 20 000 cases this year. The prevalence of HIV among all risk groups has also decreased significantly.

Since 2001, Thailand has been able to produce a combination of triple antiretroviral drugs at very low cost, and the price is going to be lowered further in the near future. This capacity, coupled with strong political commitment, has allowed the possibility of universal access to antiretrovirals: since October 2003, under the Universal Coverage of Health Insurance Scheme and with partial support from The Global Fund to Fight AIDS, Tuberculosis and Malaria, Thailand has provided universal access to antiretrovirals for all who need treatment. The target is set at 50 000 patients per year. After six months of implementation, we have reached more than 35 000 patients. Moreover, other health-care schemes, such as civil servant medical benefit, social security health insurance and private payment, have given an additional 20 000 patients access to antiretroviral drugs. No patient will be denied access to antiretrovirals any more in Thailand. The success in prevention, together with the reduction of incidence and prevalence, ensures the sustainability of this universal access.

I would like to share with this Health Assembly some of our experience. Between 2001 and 2002, we treated 8000 patients with triple antiretrovirals. However, effective compliance was only 42%. This situation occurred despite our solid and extensive health infrastructure and adequate human resources. It is therefore our great concern that the key success of the "3 by 5" initiative will depend not only on access to drugs but also on good health infrastructure, adequate and well-trained human resources for health, and strong community support. These issues need to be strongly addressed in this Health Assembly and by all concerned.

Thailand will host the fifteenth International AIDS Conference between 11 and 16 July this year. This Conference will be the first to be held in a developing country in Asia. The main theme of this Conference is "Access for All", signifying the promotion of access to essential HIV-related science, prevention, treatment and resources for all people in the world. For the first time ever, this year's International Conference will feature a full programme focusing on leadership responding to HIV/AIDS, in addition to the scientific and community programmes. The leadership programme will draw global attention to the role and concrete contribution of leaders from all sectors and in all parts of the world, including political and religious personalities, youth, women, uniformed services, business, nongovernmental organizations, media, entertainment and sports personalities. Preceding this Conference, the Second Asia-Pacific Ministerial Meeting on HIV/AIDS will be held as a follow-up to the first meeting in Melbourne. For the first time, Thailand will host the leaders' round table on HIV/AIDS, which will be chaired by the Prime Minister of Thailand and will bring together leaders of countries with significant roles in HIV/AIDS. The ultimate goal is to obtain their commitment to halting the spread and reversing the trend of HIV infection. It is therefore my great pleasure to cordially invite your excellencies and the honourable delegates to attend this important event in Bangkok. Your presence will galvanize the world's response to HIV/AIDS through increased commitment, leadership and accountability.

Besides attending the Conference, I believe you will have a great opportunity to visit our country. Thailand possesses a wealth of architecture, culture, cuisine and traditions that are distinctively Thai. Other than Bangkok, the City of Angels, you will also find numerous attraction sites all over Thailand. We will make sure that Thailand will provide an exciting venue for this Conference and that you will experience warm hospitality from the Thai people throughout your stay in Thailand. Once again, may I extend a warm welcome to everyone and see you all in Bangkok in July.

The PRESIDENT:

We thank Thailand for its tremendous work in countering the HIV/AIDS problem. WHO congratulates Thailand.

Dr HOSSAIN (Bangladesh):

Bismillah arrahman arrahim.

Over the last 30 years Bangladesh has made remarkable progress in reducing poverty, which has positively impacted on the overall socioeconomic development of the country. Life expectancy has increased, infant mortality has gone down, and we have achieved a lower birth rate. We are aware, however, that other challenges remain. Maternal mortality, for instance, which is around 322 per 100 000, remains high. We are trying to address this problem through a national maternal mortality reduction programme, with better skilled birth attendants at grass-roots level, and essential obstetric care services at the subdistrict level. Other measures introduced by the Prime Minister of Bangladesh, Her Excellency Begum Khaleda Zia, such as stipends for secondary education for all girl students, and raising the legal age of marriage, will also help to prevent adolescent pregnancies and contribute to the reduction of maternal mortality. We are hopeful of reaching the infant mortality rate and maternal mortality rate goals set out in the Millennium Development Goals.

In the area of communicable-disease control, we have been able to eliminate leprosy at the national level. Although prevalence of tuberculosis remains high, directly observed treatment, short course (DOTS) programmes are well under way. Bangladesh is currently undergoing an epidemiological transition, and the patterns of mortality are changing. According to the WHO burden of disease estimates, mortality due to communicable diseases, perinatal and maternal conditions is expected to decline from around 50% to 30% of total mortality during the period 1999-2010. However, deaths due to noncommunicable diseases, injuries and accidents are expected to increase, with road traffic accidents estimated to see an alarming rise in Bangladesh. WHO's decision to select road safety as the theme of World Health Day this year was indeed a timely one. We observed the Day in Bangladesh with renewed national commitment to the theme "Road safety is no accident". We are aware of the economic losses and suffering resulting from road accidents and injuries. Apart from causing deaths and disabilities, road accidents are also placing an added burden on our already over-stressed health care system. We have taken up a comprehensive programme to prevent road accidents and ensure road safety which includes public education programmes for safe use of roads and highways, addressing injury as a public health problem, setting up trauma centres on major highways, and treatment of trauma and mass casualty victims through a protocolized procedure.

I am happy to share with this august Health Assembly that Bangladesh has achieved remarkable progress in eradicating poliomyelitis. We have been poliomyelitis-free since 2000. We believe that it is in our collective interest to have regional collaboration among all neighbouring countries to eradicate such health challenges. Regional efforts could also be effective in dealing with outbreaks of communicable diseases which are not likely to be confined to any single country.

As regards HIV/AIDS, Bangladesh is still a low-prevalence country with a prevalence rate of less than 0.1%. We are, however, not being complacent about it and are in the process of updating our HIV/AIDS strategic plan with emphasis on prevention, reduction of stigma and discrimination, and care and support. Multisectoral efforts are under way. Nongovernmental organizations and religious leaders have been actively involved in raising awareness and disseminating information on prevention of HIV/AIDS. I am happy to report to this Health Assembly that Bangladesh was among the first

countries to sign the WHO Framework Convention on Tobacco Control last year. Last week, the Framework Convention was ratified by the Cabinet. The Cabinet also approved a bill entitled "Smoking and Tobacco Consumption Prohibition Act 2004" which will be placed before the Parliament at its next session. We hope that these matters will significantly contribute to reducing prevalence of lung cancer and cardiovascular diseases.

We have made progress on several fronts. As a consequence, over the last decade we have emerged as a medium human development country. However, access to resources and services and equitable distribution of resources, especially to the poor, remains an unfinished task for us. We developed an interim poverty reduction strategy paper two years ago and, currently, we are in the process of finalizing the paper with a more intensive strategy for economic growth, poverty reduction and social development, with the emphasis on health, population, nutrition and education. We are hopeful that with the successful implementation of this strategy, we shall be able to attain most of the Millennium Development Goals.

I wish to conclude by expressing our appreciation to WHO for its continued support in our endeavours to provide health care to millions of our people.

The PRESIDENT:

WHO commends the improvement of health indicators in Bangladesh. I now give the floor to the delegate of Mauritius, who will speak on behalf of the Southern African Development Community – that is, Angola, Botswana, Democratic Republic of the Congo, Lesotho, Malawi, Mozambique, Namibia, Seychelles, South Africa, Swaziland, United Republic of Tanzania, Zambia, Zimbabwe and his own country.

Mr JUGNAUTH (Mauritius):

It is an honour and a pleasure for the Republic of Mauritius to present this statement on behalf of the 14 states of the Southern African Development Community (SADC). Essentially, the diseases and conditions that are afflicting our subregion are related to poverty and underdevelopment. Communicable diseases like HIV/AIDS, tuberculosis and malaria continue to be sources of great concern for the SADC region. At the same time, due to changes in our lifestyle, we face an ever-increasing epidemic of noncommunicable diseases and conditions such as diabetes mellitus, hypertension, heart diseases and trauma, including road traffic accidents. Maternal and child mortality and poor nutrition are still major challenges and impede development in our region. Time and again, our region experiences episodes of natural calamities in the form of drought and floods.

SADC countries are committed to the goals that we have set for ourselves at international and continental forums. These include the Millennium Development Goals, the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, and the Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. The region also supports the health strategy of the New Partnership for Africa's Development (NEPAD), which proposes a developmental approach to addressing health matters.

The region has adopted a new HIV/AIDS Strategic Framework and Programme of Action for 2003-2007. This Framework puts greater emphasis on issues of gender, and orphans and vulnerable children and is also in line with the restructured SADC institution. The SADC Heads of State and Government Summit on HIV/AIDS adopted the Maseru Declaration on the Fight against HIV/AIDS in the SADC Region in July last year, and further approved that SADC should establish a regional fund on HIV and AIDS. The establishment of the fund was in line with an emerging consensus that developing countries need to mobilize more domestic resources to fight HIV/AIDS, tuberculosis, malaria and other infectious diseases.

Countries in the region have also developed innovative ways to address the HIV epidemic. Examples of these are the Republic of Zimbabwe's national levy for the AIDS Trust Fund that is dedicated to funding HIV programmes and the "Songs for Africa", an initiative led by His Majesty, the King of Swaziland.

SADC countries have made significant progress on malaria, as illustrated by the following examples. First, the region commissioned a report on progress regarding the targets set in the 2000 Abuja Declaration on Roll Back Malaria in Africa. The report concluded that significant progress had been made in the attainment of the Abuja targets overall. Second, all countries in the region have a national health policy with a strong component of decentralization. In this regard, most countries in the region have district plans reflecting the priorities outlined in their national health policy. Third, over the years partnerships in malaria control have been established with organizations and institutions such as nongovernmental organizations, international aid agencies, research institutions, universities, the SADC military health services and the private sector. Fourth, most SADC countries celebrate SADC Malaria Day, which falls on the second Friday in November each year. And fifth, a regional proposal has been developed for submission to The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria.

We are on course in our efforts to achieve the goal of a poliomyelitis-free region by 2005. Several countries in the region will hold national immunization days this year, and as far as possible we will try to coordinate these campaigns across the region. The recent report of an imported case of poliomyelitis in Botswana, which was hitherto a poliomyelitis-free country, demonstrates that as long as pockets of poliovirus exist anywhere in the world, all countries will remain at risk of importation of the disease.

A major limitation to our success in addressing these diseases and conditions is poor infrastructure and weak health-care delivery systems. Our countries are plagued by inadequate infrastructure, transport, laboratories and other essential equipment, a severe shortage of human resources and supplies such as pharmaceuticals, and inadequate financial resources. In a bid to address the critical shortage of human resources, our region has been active in supporting international initiatives such as the Commonwealth Code of Practice for the International Recruitment of Health Workers and its companion document. The signing of this Code by all affected Member States will send an encouraging signal that there is a political commitment to address this matter in a fair manner. We will also be pursuing this matter during this Health Assembly. Access to affordable, quality medicines is essential, and to this end the SADC region is involved in a process of harmonizing the registration requirement for medicines.

The needs of the countries in the region are far greater than the resources available to them. External assistance by development partners is the norm in most countries. We want to register our appreciation to all international partners that have been assisting our countries by supporting the provision of health care. We would, however, like to echo the sentiments expressed by the ministers of health of the African Union by stating that partners need to harmonize and coordinate their activities. In addition, they need to streamline their procedures to improve access to and promote efficient utilization of resources. We would also like to highlight the special situation of some countries in SADC that are deemed to be middle-income countries, or countries with a high per capita income level. Such countries are excluded from most sources of development assistance, for example, The Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunization (GAVI). We appeal that the criteria for eligibility for funding by some of these institutions be reviewed to enable these countries like Mauritius also to benefit from assistance to fight HIV and AIDS and procure the WHO-recommended vaccines for the Expanded Programme on Immunization.

I would like, on behalf of the SADC countries, to extend our collective appreciation to WHO for the assistance it renders to our individual countries and the SADC subregion. In particular, we thank the Regional Director for Africa, Dr Samba, for the leadership he has provided to our region. May I also take this opportunity to congratulate South Africa on winning the bid to host the 2010 soccer World Cup. We hope that the whole African region will use this event to promote healthy lifestyles and, especially, the value of physical activity.

Our region is faced with major challenges, but we are optimistic that, through our actions as countries, through our collective efforts as SADC member states, and through support from our partners, we will overcome these.

The PRESIDENT:

Thank you. I congratulate Mauritius for working on access to affordable medicines in the southern African region.

Mr KRISTJÁNSSON (Iceland):

I would like to begin by especially thanking the Director-General for a very stimulating speech and also for giving us the opportunity to listen to the very important story and message that Anastasia brought us.

Globally, the HIV/AIDS epidemic is an enormous ongoing burden to humanity. The threat to humanity is of such magnitude, not only in Africa but also in eastern Europe and Asia, that the fight against the epidemic must have the highest priority. Therefore, Iceland welcomes and supports the initiative of the Director-General to provide HIV/AIDS treatment to three million people by the end of 2005 – the "3 by 5" initiative. This is indeed an important and brave step toward the long-term goal of universal access to drug treatment for HIV/AIDS. Iceland has decided to support this initiative financially with 15 million Icelandic kronas.

While realizing the importance and urgency of bringing treatment to those who are most in need of it, there are issues other than treatment to consider. Prevention and care must be integrated with treatment. In fact, if we succeed in bringing treatment to HIV/AIDS patients and preventing mother-to-child transmission, there will be a unique opportunity to integrate treatment with information and programmes for prevention.

To be successful, we need to strengthen primary health care in countries hit hard by the epidemic. This will also create an opportunity to combat other diseases such as tuberculosis, malaria and vaccine-preventable diseases. At the same time, we have to keep in mind that, in the absence of an effective vaccine, there is a threat related to treatment. The threat is resistance of HIV to drugs. Only a sustainable primary health care system securing regular drug delivery to patients may counteract drug resistance.

Although there are many stakeholders in the fight against HIV/AIDS, the role of WHO cannot be underestimated. WHO is the expert organization. It must give technical support, advice on best practice, and lead the way to go.

Dr UEDA (Japan):

On behalf of the Government of Japan, I would like to express our gratitude for the opportunity to present our position on the issues that concern the present Health Assembly.

The severe acute respiratory syndrome (SARS) epidemic taught us our limitations. We cannot control infectious diseases alone but, in this age of high-speed cross-border transportation, we need international cooperation for effective containment. WHO plays a pivotal role in securing that cooperation and protecting global health. We also realized that, to enable WHO to meet expectations, each Member State must play its given role. Japan is committed to vigorously taking part in regional activities as a member of the Western Pacific Region and, as a member of the international community, wholeheartedly supports WHO, with particular emphasis on infectious disease control.

Since his inauguration last July, Dr Lee Jong-wook has filled Dr Gro Harlem Brundtland's shoes well and enthusiastically addressed a wide range of issues. We highly commend his efforts. Above all, we strongly support his proposal to decentralize WHO. This policy reflects Dr Lee's outcome-oriented philosophy. In particular, considering the diversity of health issues each country or region faces, and the way these should be handled, we believe that true devolution is sorely needed, including authorities and budgets for regional and country offices. True devolution must be accompanied by a high level of competence on the part of devolved regional and country offices, and they must still function as "one WHO". To achieve this goal, we look forward to Dr Lee's continued determination and commitment.

HIV/AIDS is one of the most formidable threats we face today, and is our highest priority. It must be tackled with international solidarity. Japan has long been committed to HIV/AIDS control and

prevention through WHO, UNAIDS and The Global Fund to Fight AIDS, Tuberculosis and Malaria, and we strongly support WHO's leadership in promoting the "3 by 5" initiative with its partners. At the same time, we have consistently emphasized the importance of prevention and the development of public health systems which minimize the advent of drug-resistant strains. We have also stressed the importance of regional or even country-specific approaches because of the significant differences in the situation of HIV/AIDS, including the infrastructure to fight HIV/AIDS. We expect WHO to facilitate this initiative with its partners in a way that will be praised in the future as a historic first step. In addition to HIV/AIDS, infectious disease control, including SARS and avian influenza, has been a top priority of our international cooperation policy.

Noncommunicable diseases have also grown rapidly as a major health threat, even in developing countries in the course of health transition. Japan has promoted prevention through the "Healthy Japan 21" programme with specific output indicators. We believe that this issue must be addressed through a close international network, particularly when trade in food and other goods has become so globalized. To this end, we expect that every country will actively tackle this issue, and that WHO will provide the leadership to support its Member States.

SARS claimed many lives, including those of health-care workers dedicated to controlling the epidemic. WHO suffered its share of loss, reminding all of us who are committed to the cause of public health of the imminent danger faced and sacrifices made by colleagues in the line of duty. We pay homage to their heroism and courage, and we draw inspiration from them to continue our struggle against disease for a healthier world.

Japan is committed. And I know that all the people who are gathered here for this Health Assembly are committed. I firmly believe that, when the international health community demonstrates its solidarity, despite each country's different principles and beliefs, that is the time when WHO will spread its wings and we can all be proud.

The PRESIDENT:

Thank you very much, honourable delegate of Japan for the good work being done in the health sector.

Ms KING (New Zealand):

Can I begin by congratulating you, Dr Lee, on an excellent speech and on bringing Anastasia to this hall today to share with us her story. I have to say that I was very moved indeed by her story.

New Zealand has been one of the lucky nations in the world to date in terms of the global AIDS epidemic. The fact that the epidemic started later in New Zealand than in other countries allowed for quick responses at political and community levels. Since the global outbreak of the disease, 805 people have been diagnosed with AIDS in New Zealand, and 2075 people have been infected with HIV.

Compare those statistics with the reality that exists in many African countries. Three million people died of AIDS last year, by far the most of them in Africa, and I understand it is estimated that there are 15 000 new infections every day. In Botswana, a small country of just 1.6 million people, between 35% and 40% of everyone aged between 15 and 49 is infected with HIV. Those sorts of figures are almost beyond the comprehension of New Zealand, a small country of just 4 million people, remote from much of the rest of the world. But that remoteness cannot shield New Zealand from global pandemics, and certainly cannot shield it, as a relatively wealthy nation, from a responsibility to play as full a role as it can in global initiatives and solutions to curb and, ultimately, to end the pandemic.

That is why New Zealand is excited by WHO's determination to have three million people receiving treatment by 2005. That is why New Zealand is also pleased to see the price of antiretroviral generic drugs coming down. That is why New Zealand is relieved that more and more countries now seem prepared to admit that women and girls need to be empowered to have control over their own sexuality, because until they do, everywhere, the pandemic will continue.

But none of these advances, whether in will or in practical initiatives, will do anything but slow down the pandemic, or provide a more humane face to the way the world deals with it. We must do more. The world must find a way to end the pandemic. We must find a vaccine that brings this ongoing tragedy to an end. I will return to that need shortly, but first I would like to discuss briefly the current situation in New Zealand.

The response to the epidemic in New Zealand is generally based on a health promotion approach and follows the Ottawa Charter for Health Promotion. In November 2003 a reviewed, updated and extended HIV/AIDS Action Plan was released in New Zealand. The Plan reflects expanded targeting of health promotion and education programmes and services to the most vulnerable groups. Gay community groups played a central role early on in New Zealand in developing strategies to combat the epidemic and, as HIV posed a potential risk to other population groups, organizations based in those communities have also formed over time. So civil society has been a key to controlling the spread of HIV/AIDS in New Zealand. Clearly, we need to continue to modify and refine our approach as new issues emerge and we need to start trying to achieve behavioural change now. But achieving behavioural change is difficult. In some countries there has been a drop in condom use among men having sex with men, and in New Zealand the AIDS Foundation reports similar fears. Younger men, who have not experienced the epidemic first hand, are a particular concern. There may also be complacency because of the increased efficacy of medications in prolonging life, and a perception that adhering to safe sex is not so important now. We accept the reality that there is no room for complacency.

New Zealand also has a responsibility to work alongside its Pacific neighbours in developing initiatives to combat the epidemic. In addition to the development assistance channelled through the United Nations and other international agencies, New Zealand has funded three Pacific HIV/AIDS initiatives through special international partnerships, and yesterday I announced a further 3 million New Zealand dollars for programmes directed towards the Pacific region. We also support projects in areas such as reducing violence against women and enhancing women's status, both important components of HIV/AIDS prevention. All these programmes are valuable, but none can do more than slow down the pandemic. The world does need to deal it a decisive blow, and we will not do that without a vaccine.

I was extremely moved by an address given by Stephen Lewis, the Secretary-General's Special Envoy for HIV/AIDS in Africa, to the Rotary Club of Toronto in January this year. He conveyed a picture of Africa that was inevitably bleak, with "sad, desolate stories" related by grandmothers in South Africa who talked to him of losing both their children and their grandchildren. Heartbreaking though much of the content of his speech was, he also conveyed a strong sense of energy and hope, and, most importantly, he called powerfully upon what should be our common humanity.

Stephen Lewis's immediate challenge was to Rotary International, but in a wide sense it was a challenge to us all. Recalling Rotary International's immense contribution in financial terms to the campaign to eradicate poliomyelitis, Mr Lewis said that Rotary International now needed another cause, and that cause should be HIV/AIDS, particularly focusing on the development of a vaccine. New Zealand strongly backs his call. Common humanity demands the support of all of us.

The PRESIDENT:

Thank you, the honourable delegate of New Zealand, for the good work on HIV/AIDS and working against violence against women.

El Sr. COSTA LIMA (Brasil):

Señor Presidente, señor Director General, honorables delegados y participantes: en todas las Asambleas Mundiales de la Salud uno o dos temas del orden del día destacan y terminan por concentrar buena parte de nuestra atención. Este año, como no pudiera ser diferente, un tema sobresale por su importancia clave para el desarrollo de las políticas de salud y por la amplitud de su carácter multisectorial.

Me refiero al tema «Nutrición, actividad física y salud», sobre el cual tendremos que ocuparnos llegado el momento de su consideración. Más allá de las críticas que se pudieran hacer con relación a los fundamentos de la propuesta de estrategia global, lo más importante es darse cuenta de que existe en el mundo un muy grave problema de salud asociado a dietas no saludables.

El Brasil no es una excepción en la constatación global de ese hecho. Aun llevando en consideración la situación de pobreza en que se encuentra aproximadamente un tercio de la población brasileña, los hallazgos epidemiológicos acusan una seria carga de enfermedades crónicas degenerativas entre grupos de personas de bajos ingresos. Además de las enfermedades transmisibles, siempre más presentes en los países en desarrollo, el aparecimiento de las enfermedades crónicas degenerativas en aquellos países constituye un fenómeno nuevo que no puede ser ignorado al propugnar políticas de salud pública. La llegada al sur de enfermedades hasta ahora típicas del hemisferio norte constituye una amarga ironía. Es, por lo tanto, imprescindible que apoyemos los esfuerzos para que la propuesta de estrategia mundial sobre régimen alimentario, actividad física y salud se constituya en marco de referencia para la elaboración de políticas nacionales que tengan en la salud, en la dieta y en la actividad física sus principales elementos.

Ésta es también una oportunidad para que reflexionemos sobre el impacto del régimen de propiedad intelectual sobre la salud pública. No podemos perder de vista el bosque por culpa de los árboles. Lo más importante para los países en desarrollo es poder garantizar el acceso a la asistencia a la salud, que no puede hacerse plenamente si no garantizamos al mismo tiempo el acceso a los medicamentos. Tenemos que ser claros al respecto. La exclusión de la mayor parte de la población mundial del acceso a los medicamentos es moralmente injustificable y económicamente errónea. La Comisión sobre Propiedad Intelectual, Innovación y Salud Pública, presidida por la Dra. Ruth Dreyfus e integrada por figuras sobresalientes de ese campo, tiene la enorme responsabilidad de examinar la cuestión del impacto sobre la salud pública del régimen de patentes de medicamentos. Es muy importante que sus resultados no se vean oscurecidos por cuestiones económicas y comerciales que, por muy importantes que sean, deben subordinarse a las necesidades de salud pública y a la universalización del acceso a los medicamentos. Es absolutamente necesario ser claros respecto del acceso. Más allá de los puntos relativos a la organización de los servicios de salud o de la adhesión del paciente a los tratamientos, la cuestión del acceso está íntimamente vinculada al nivel de los precios de los medicamentos. Y de poco adelanta promover políticas públicas de salud si no es posible, por una cuestión de precios, con fuerte impacto sobre los presupuestos nacionales, acceder a los medicamentos necesarios para los tratamientos.

No puedo dejar de mencionar una vez más el decidido apoyo de mi país a la muy oportuna iniciativa del Director General de la Organización con la puesta en marcha de la iniciativa de extender, hasta el año 2005, el tratamiento del VIH/SIDA a tres millones de enfermos. La iniciativa «3 por 5», como se la conoce, es una demostración de coraje por parte de la Organización, que tenemos que apoyar de manera imperativa. Todos tenemos esperanza de que esta iniciativa no se frustre por una visión estrecha y egoísta de intereses ajenos a la salud pública. El Brasil vuelve a reiterar su disposición a facilitar el tratamiento para dos millones de personas con VIH/SIDA diagnosticado, mediante la utilización de medicamentos antirretrovirales genéricos, en el marco de su programa de cooperación internacional. Y aprovecho para insistir en que la utilización de los medicamentos genéricos es esencial para el tratamiento continuo y sostenible de pacientes con patologías crónicas.

El último punto sobre el cual me detendré es el relativo al tabaco. Este año, el Día Mundial sin Tabaco, que se celebra el 31 de mayo y tiene como tema «Tabaco y pobreza», tendrá en el Brasil el centro de sus actividades. Al respecto, tengo la inmensa satisfacción de informar a este pleno que el Presidente Luiz Inácio Lula da Silva decidió incluir el tema del tabaco en la agenda del desarrollo con el propósito de identificar y superar las contradicciones de la industria del tabaco en lo que respecta al anhelo de la sociedad de superar los obstáculos a su completo desarrollo.

The PRESIDENT:

Thank you very much, the honourable delegate of Brazil. I compliment you for the diet and physical activity work that is going on and for the support that you give.

I would like to ask the first Vice-President, Dr Rui Maria de Araujo (Timor-Leste) to take over from me for the rest of the day.

Dr R. Maria de Araujo (Timor-Leste), Vice-President, took the presidential chair.
Le Dr R. Maria de Araujo (Timor-Leste), Vice-Président, assume la présidence.

Dr TSHABALALA-MSIMANG (South Africa):

I would like to express my sincere appreciation to the Member States gathered here for electing me one of the Vice-Presidents of this Health Assembly. It is a great honour for me and my country, South Africa. I also thank you for the opportunity to address this Health Assembly and to share some of our thoughts as a country, as we mark the tenth anniversary of our democracy and freedom in South Africa. Thank you all for the important assistance you gave us during the bitter and difficult years of our struggle.

I have used the twin concepts of "democracy" and "freedom" because we set out to build a particular kind of society 10 years ago. We wanted to create a nation that was the complete opposite of the heartless and cruel system of apartheid. We therefore went beyond the basic democratic requirement of universal franchise and saw to it that the freedoms that are essential to human rights were placed at the centre of our new system of government through our new Constitution. The Bill of Rights not only guarantees all the basic freedoms that were so brutally denied our people in the past – freedom of association, freedom of movement and freedom of speech: among its provisions is the recognition that every human being has a right to the basic necessities of life, including the right to quality health care. Our Constitution charges us, as government, with ensuring access to these necessities.

In the 10 years since the African National Congress assumed the reins of government, we have made a mighty effort to meet our obligations in terms of socioeconomic rights. The poor of our country are now entitled to and are receiving basic services that are critical to improving health, including education opportunities, land and basic shelter, a free quota of piped water and electricity, free primary health care and free health care at all levels for pregnant women, children under six years and people with disabilities, and noncontributory social grants for old people, children and people with disabilities. Of course, much more still needs to be done.

The human rights culture has had a profound impact on health service provision in our country. We have focused our programmes on vulnerable groups like children, women and people with disabilities. Our capital spending has targeted rural communities, providing hundreds of new clinics and appropriate hospital facilities. We have involved communities in service provision – for example, through national immunization weeks, the rapid expansion of home-based care and the training of thousands of community health workers.

We have made major strides in making quality medicine more accessible and affordable to all. Our interventions have had a major impact in addressing major communicable diseases including cholera, measles and malaria. We are implementing a comprehensive strategy on HIV/AIDS that covers all the elements needed to deal effectively with this major challenge. Also critical is the strengthening of our tuberculosis interventions to increase cure rates. It is these achievements that prompted almost 70% of our population, through their votes, to give the African National Congress yet another resounding mandate to improve their lives.

The successful launch of the African Union and the establishment of the Pan-African Parliament demonstrate our commitment to promote the universal principles of equality, freedom and democracy. The New Partnership for Africa's Development (NEPAD) encourages our partnership as Africans with the rest of the world as equals. The successful bid to host the 2010 Soccer World Cup in South Africa is one major outcome of this equal partnership. Our individual attempts to host this event on previous occasions failed. However, once we united and spoke with one voice, this Cup came to our continent.

We are determined as Africans to make this our century. Our right to participate as equals in the world arena can no longer be ignored. Transformation of world institutions to include all people and eliminate marginalization of poor societies must top the agenda of the world. Africa has a wealth of

potential, not only to realize its own development goals, but also to create the united world we all envisage.

Dr KIM (Republic of Korea):

Allow me to begin by expressing my profound respect and gratitude to the Director-General, Dr Lee, and WHO staff for their dedicated efforts in combating emerging and re-emerging diseases and protecting human health from such threats as poverty, disasters and conflicts.

The Republic of Korea, in close cooperation with WHO and other countries, has successfully controlled SARS and other communicable diseases. As part of our effort to further reinforce control of communicable diseases, we have strengthened the national surveillance system with advanced information technology and established the Korea Center for Disease Control and Prevention.

WHO is working to revise the International Health Regulations in an effort to strengthen preparedness for emerging diseases. Fully recognizing the significance of this action, I would like to reiterate my proposal from last year that all Member States work together to establish a global surveillance system, utilizing rapidly growing information technology. The Republic of Korea is more than willing to do its part in such an endeavour.

AIDS kills millions of people every year. This is a worldwide problem spreading in every region. As life-threatening as it is, HIV/AIDS is becoming increasingly manageable thanks to the recent development of new therapies. In this regard, we welcome and support the ambitious "3 by 5" initiative of WHO. Wide participation of various actors in the mobilization of expertise and resources is a critical element for the success of the initiative. We believe that WHO, under the leadership of the Director-General, and with the cooperation of Member States, international organizations and civil society, will play a central role in achieving the goal of the initiative. The Republic of Korea will continue to support the Organization's efforts and gradually increase our contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

On 22 April, a tragic accident happened in the Ryongchon area of the Democratic People's Republic of Korea. Many people, including children, were killed and injured in a train explosion. Support from the international community has made, and will make, a huge difference in the recovery of the disaster area. The Republic of Korea provided financial support through WHO, as well as emergency kits and medical supplies sent directly to the Democratic People's Republic of Korea. In this process, the recently-established Korea International Foundation for Health and Development played an important role. The Foundation will provide assistance to any part of the world hit by accidents or disasters. We welcome your interest in, and support for, this Foundation.

We have a multitude of important agenda items to discuss in this Health Assembly: HIV/AIDS, family and health, the draft global strategy on diet, physical activity and health, primary health care, reproductive health and other issues essential for the healthy future of humanity. I sincerely hope our extensive discussion in these areas will lead to significant improvements in global health.

Mr BIADILLAH (Morocco): السيد محمد الشيخ بيد الله (المغرب):

بسم الله الرحمن الرحيم،

السيد الرئيس، السيد المدير العام، أصحاب المعالي والسعادة، حضرات السادة والسيدات، يسرني، في بداية هذه الكلمة، أن أتقدم إلى رئيسنا الحالي وأعضاء مكتبه أصالة عن نفسي ونيابة عن وفد المملكة المغربية بأحر التهاني بمناسبة انتخابكم سيدي الرئيس رئيساً لهذه الدورة، متمنياً لكم كامل النجاح والتوفيق في تسيير أعمالنا.

كما يطيب لي أن أتوجه بأصدق عبارات التقدير والاحترام إلى السيد المدير العام الدكتور جونغ - ووك لي مقدراً مجهوداته القيمة الهادفة إلى تعزيز الأهداف المرسومة من طرف منظمتنا وأثمنّ عالياً الشهادة الحية التي تفضلتم بإعطائها لنا برواية السيدة أناستازيا وأنا أتذكر أن هناك العشرات منها في غرب الكرة الأرضية اللواتي يمتن بصمت كالحمائم. وهناك العشرات من الأناستازيات في الشمال طبعاً يتمتعن بالاستشارة الدوائية والولوج بسهولة إلى الخدمات الصحية والدواء الموجود والمتابعة والتقييم. وفعلاً هذا هو التحدي الذي نعيشه الآن في عالمنا المخيف الظالم الذي يغير كل شيء حولنا.

دعوني أعدْ إلى الأيدز سيدي الرئيس لكي أنوه كذلك بمبادرة " ٣ قبل ٥" التي تفتح في الواقع آمالاً عريضة أمام جماهير الجنوب وبالتالي فهي بالنسبة لكم تحد كبير فيما يتعلق بإنجاحها لأن الانتظارات كبيرة وكبيرة جداً. ولدينا في المملكة تجربة بسيطة في هذا الميدان ونعتبر أنه لإنجاح هذه العملية ليست هناك في الواقع وصفة جاهزة ولكن نعتبر أن هناك حداً أدنى للعمل السليم في هذا الميدان. أولاً: أظن أنه لابد من إرادة سياسية واضحة وعلى أعلى مستوى، ثانيا: نعتبر أن تعبئة المجتمع المدني وجميع الشركاء ومشاركتهم في القرار في الإنجاز في التتبع على أصعدة مختلفة على صعيد الوقاية، وعلى صعيد العلاج، وعلى صعيد المتابعة، وكذلك على صعيد التقييم. نعتبر كذلك أن هذا البرنامج لابد أن يزرع على برنامج تنفيذي وطني محدد واضح المعالم ومتفق عليه يرتكز على موارد مالية قارة وخبرة ميدانية متجددة ونفس طويل لضمان استمراره وتطويره وطبعاً وتحيينه.

لابد كذلك أن تنسق الحكومات الوطنية مع جميع المتدخلين وقائياً وشفائياً وأن تعمل على تهييء الموارد البشرية الكافلة والكافية وأن تشجعها وأن تضمن لها التكوين المستمر وأن تتابع وتحيّن وتقيّم أعمال الفرق المتدخلة في أوقات محددة مسبقاً بتعاون مع جميع الشركاء محليين كانوا أو دوليين. لابد كذلك، وهذه عملية صعبة، من تعزيز قدرات المنظومة الصحية الوطنية إجمالاً لكي تستقبل بسهولة الوافدين عليها في استعمالها.

سيدي الرئيس، ظهرت أول حالة للأيدز في بلادنا سنة ١٩٨٦ ورغم قلة الوسائل فإن بلادنا تمكنت من رصد وتتبع واستشفاء الحالات التي تم رصدها وذلك بفضل الالتزام السياسي لجلالة الملك محمد السادس شخصياً في محاربة هذه الآفة وهذه الجائحة وفي الواقع في تحريك دواليب الدولة والمجتمع المدني للوقوف في وجه هذا المرض المخيف. وفعلاً فقد وجه جلالة الملك نداءً إلى هيئة الأمم المتحدة في دورتها الخاصة في نيويورك ٢٠٠١ وأعلن عن استراتيجية وطنية محددة لمجابهة هذا الداء.

وبفضل هذا البرنامج الذي تم إنجازه تمكنت الحكومة من شيء مهم وهو التنسيق بين تدخلات جميع الشركاء محليين أو دوليين وبدأت الحكومة في إضفاء الطابع الإجرائي على هذه الاستراتيجية مما مكننا الآن من متابعة ومراقبة ورصد الوضع الوبائي بصفة عامة وترصد وتشخيص أغلب الحالات وتقديم العلاج الثلاثي لجميع المصابين وتكثيف عملية الوقاية.

أريد أن أذكر بأن التشخيص والعلاج والمتابعة تتم مجاناً في مستشفياتنا لجميع المصابين أولاً بسرية كاملة وهذا شيء مهم جداً حتى عملية التشخيص تتم بسرية كاملة وهناك أرقام هاتفية موضوعة رهن الجمهور لكي نحافظ على هذه السرية، وكذلك تتم في احترام حقوق المصابين وصون كرامتهم ولم يكن إلى حد الآن هناك أي مشكل فيما يتعلق بالتمييز وهذا شيء مهم. وقد واكب مختلف الشركاء هذا العمل بجدية ونضالية ووعي جعلهم الآن يشاركون الحكومة أولاً في نشر الوعي بين السكان في توزيع الأدوية، في مراقبة الحالات الجديدة ورصدها وفي تتبع حالات المصابين وتحسيس باقي المجتمع بخطورة هذا الوباء الخطير. وكذلك أهمية

الوقاية، وكذلك لكي يعرف الجمهور أن هناك إمكانية للعلاج وهذا طبعاً شيء مهم. ومع ذلك فلازال تطور هذا الداء على المدى البعيد يخيفنا نظراً لانفتاح بلادنا على العالم ولجوارها لأوروبا ولانفتاحها على محيطها الأفريقي وهذا شيء طبيعي.

طبعاً سيدي الرئيس، تعيش بلادنا في هذه الظروف تحولات عميقة: تحولات ديموغرافية حيث تتجه الآن التركيبة السكانية للشيخوخة. معدل العمر عندنا هو ٧٠ سنة، تحولات وبائية متلاحقة متسارعة، تحولات طبعاً اجتماعية اقتصادية وسياسية. وفي هذا الخضم يبقى مشكلة التمويل وتأهيل المنظومة الصحية وإيجاد دواء لائق والمختبر القادر على التشخيص والأطر الطبية وشبه الطبية القادرة على المتابعة والمثابرة والرصد والنصح يبقى تحدياً كبيراً جداً ووسائلنا طبعاً ضئيلة ولكن تم الآن على صعيد الحكومة اتخاذ قرار مهم وهو تعميم مشروع التأمين الصحي وجعله إجبارياً وشاملاً وسيطبق تدريجيا انطلاقاً من السنة المقبلة إن شاء الله في ظروف طبعا مادية صعبة كما تعرفون.

ويرتكز هذا المشروع أساساً على روح التضامن والتكافل بين جميع فئات شعبنا تجسيداً لمبدأ محاربة الإقصاء تنفيذاً لتعليمات جلالة الملك.

يبقى أن محاربة الفقر والإقصاء والاستجابة لمتطلبات الفئات الأكثر احتياجاً هو الذي يؤرقنا وسيكون طبعاً في خضم المعركة المقبلة لأزرأة هذا القانون.

لا يفوتني سيدي الرئيس في هذه المناسبة أن أذكر ولو مروراً بصعوبة الأوضاع الصحية التي يعيشها الشعبان الشقيقان الفلسطيني والعراقي وهي وضعية لا شك أنكم متفقون معي جميعاً تسائل الضمير الإنساني برمته وتفرض علينا جميعاً توجيه الدعم اللازم واللامشروط والعاجل للتخفيف من محنة الشعبين الفلسطيني والعراقي تكريساً لقيم التضامن بين الشعوب والأمم.

والسلام عليكم ورحمة الله تعالى وبركاته.

Mr NAVEH (Israel):

The discussions in today's round tables on HIV/AIDS demonstrate once again our need to better meet the medical, social, economic and heath challenges related to HIV/AIDS. As a multicultural society with immigrants coming from over 80 countries, Israel realizes the urgency of mobilizing financial and human resources to halt the spread of HIV, which knows no borders. Situated at the crossroads of Africa, Asia and Europe, Israel is ready to share with affected countries – and in partnership with WHO and its "3 by 5" initiative – our experience and expertise in preventive education and capacity-building.

Noncommunicable diseases are the biggest public health challenge in Israel. These diseases impose a major economic burden on our health system. We support the WHO draft global strategy on diet, physical activity and health.

Israel congratulates the leadership of WHO in dealing with the SARS epidemic. WHO demonstrated a rapid and coordinated response, which proved its vital role in public health. Israel, like many other countries, is expecting WHO to give guidelines and take a central role in formulating the policy for procurement of medications for the potential pandemic of influenza which can develop from avian influenza.

Israel recognizes the issue of road safety and accidents as a factor of modern life. We must address the causes and consequences of this epidemic. We congratulate WHO for highlighting this issue, in the hope that coordinated worldwide information and ideas may benefit all the people who suffer the tragic results of accidents in an automated world. Israel is a tiny country, founded in 1948 with less than a million inhabitants. In 56 years of independence we have absorbed several million new immigrants into our ancient homeland. Despite its unprecedented development, the country's infrastructure has not always been able to keep pace with the influx of population. We have lost more lives on the roads than in all our wars, including our horrific struggle against terrorism. The associated financial loss of US$ 2 billion represents 2% of our gross national product, compared to 1.4% in Europe. As Minister of Health in charge of one of the most sophisticated health care systems, I find two redeeming factors in the unfortunate experience we have gained through battle and terror: first, we have been able to eliminate some of the causes of road accidents through immense investment in highways, extended police patrols and safety campaigns to increase civilian awareness, and second, we can better deal with the results of road accidents through medical care and the rehabilitation of victims.

Israel is prepared to work together with its neighbours in the region, both in the Middle East and in the Mediterranean, to promote environmental health and the surveillance of communicable and noncommunicable diseases, including obesity, diabetes and cardiovascular diseases. The exchange of know-how and joint initiatives could enhance awareness, increase the possibility for mutual support in the prevention and treatment of a variety of health issues and make our environment a safer and healthier one.

Professor HEBRANG (Croatia):

Croatia highly appreciates the fact that the debate in plenary at the Fifty-seventh World Health Assembly focuses on HIV/AIDS, which is now the leading cause of deaths worldwide and one of the worst global epidemics. My country shares the views of the international community that much still needs to be done on the national, regional and global levels as the challenge posed by this epidemic remains as large as ever. Only coordination of the three levels will allow for effective action to stop the negative impact of the epidemic.

In looking for a comprehensive approach, Croatia has taken a number of measures on the national level. A commission for the prevention of HIV/AIDS was established in 1990 by the Ministry of Health. Three years later the Croatian Government adopted a National AIDS Protection Programme which established wide-ranging approaches addressing HIV/AIDS-related problems, including large-scale peer education, voluntary testing and counselling, blood and blood products safety measures, and the establishment of both a reference, testing and treatment centre and a framework for involving nongovernmental organizations that target vulnerable groups. Moreover, highly active antiretroviral treatment was introduced through the national insurance scheme in early 1998 and since then is available free of charge to all persons living with HIV/AIDS in Croatia. In order to establish a truly multisectoral approach to the HIV/AIDS problem and to widen its scope of action, the national HIV/AIDS prevention commission was replaced in 2003 by a governmental committee for the suppression of HIV/AIDS, which is fully committed to fighting HIV/AIDS in Croatia. In all our activities we were supported, inter alia, by WHO, which Croatia highly appreciates.

Although fewer than 450 cases of HIV/AIDS infection have been recorded in Croatia and all other data indicate a low-level HIV epidemic, we are fully aware that we are very close to eastern Europe where the fastest-growing HIV epidemic rate in the world is currently observed. The geographical location of Croatia as a transit country, an economy based to a great extent on tourism, as well as the growing number of vulnerable populations, represent factors that favour the possible spread of HIV/AIDS in Croatia. Therefore, the Croatian Government, with the assistance of many international organizations, is focusing on policies and strategies that will make the public more sensitive to the HIV/AIDS issue, especially for the most vulnerable groups – children, young people and women – while at the same time trying to engage civil society in the national response to the epidemic. We are also committed to fight against fear and discrimination of people living with HIV/AIDS. Education and preventive programmes in schools and universities targeting teachers, students, and risk groups are playing a major role in the Croatian HIV/AIDS policy.

Major progress has been achieved and a great deal of effort has been invested in coordinating the activities of the Government and nongovernmental sector. As a result, the Ministry of Health subsidizes the work of several nongovernmental organizations as well as health institutions dealing with HIV-positive patients. Moreover, since January 2002 Croatia has been participating in The Global Fund to Fight AIDS, Tuberculosis and Malaria. Since August 2003 this Fund has been financing a project dealing with peer education in the education system, reducing the risk of infection in risk populations, making voluntary testing for HIV and counselling more accessible, raising the quality of health protection and increasing the quality of monitoring the spread of infection. In autumn 2003, in collaboration with the WHO Regional Office for Europe, the Andrija Štampar School of Public Health in Zagreb (whose founder, Dr Andrija Štampar, was the President of the First World Health Assembly) became one of three "knowledge hub" centres for central and south-eastern Europe. The joint efforts of this project will focus on HIV/AIDS surveillance so as to enhance the system of prevention and monitoring of HIV/AIDS cases in the region where, according to WHO estimates, more than a third of those with AIDS remain unregistered. In this regard, the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia adopted in February this year and the Declaration of Commitment on HIV/AIDS agreed at the United Nations General Assembly special session on HIV/AIDS at the end of June 2001 provide, without any doubt, the basis for future national policies and cooperation in Europe and on the international level.

We strongly support the "3 by 5" initiative launched in December 2003 by WHO and UNAIDS to provide three million people in developing countries with antiretroviral therapy by the end of 2005.

Croatia welcomes *The world health report 2004. Changing history* launched a week ago and fully agrees that by using HIV treatment programmes to strengthen existing prevention programmes and improve health systems, the international community has a unique opportunity to change the course of history.

El Dr. TAPIA (México):

Señor Vicepresidente, señor Director General, delegadas y delegados: reciban un cordial saludo a nombre del Gobierno de México y en particular del Secretario de Salud, Dr. Julio Frenk, con los más amplios deseos de que esta Asamblea sea exitosa y de trascendencia para la salud de nuestros pueblos.

Los problemas que en salud enfrenta la humanidad representan un reto para todas las naciones. No sólo por el surgimiento de nuevas y variadas enfermedades o la aparición de nuevos agentes causantes, sino también, porque constituyen un reto para la organización de la prestación de servicios de salud, ya que ponen a prueba la capacidad de respuesta de los gobiernos y de los organismos multinacionales, requiriendo, cada vez más, una respuesta globalizada en la que se requiere la participación de organizaciones no gubernamentales y genera la corresponsabilidad de los individuos en el autocuidado de su salud.

Ejemplo de estos retos es el VIH/SIDA, que representa un claro desafío a nuestra capacidad de respuesta. Por eso nos congratulamos con el hecho de que nuevamente este tema sea abordado en una Asamblea Mundial de la Salud, por ser un problema que no se solucionará exclusivamente con declaraciones y buenos propósitos, sino que requiere un amplio compromiso, esfuerzo, decisión, pero sobre todo, la acción de todos los involucrados.

La política nacional de México frente al VIH/SIDA se basa en la prevención, la atención médica integral, el respeto a los derechos humanos y una participación activa de la sociedad. La epidemia en México se mantiene con una de las menores tasas de incidencia del continente americano, y sigue teniendo características concentradas en grupos poblacionales específicos. Este hecho no es casual, sino que responde a las estrategias preventivas adoptadas por nuestro país desde el inicio de la epidemia.

En las mesas ministeriales que sobre el tema hemos tenido el día de hoy, hemos refrendado el compromiso de hacer frente a este problema. Variadas acciones e ideas han sido discutidas, y diversos avances han sido presentados. En países de ingreso medio como México, además de asegurar la cobertura universal del tratamiento con antirretrovirales, también debemos cuidar los siguientes elementos:

- Al garantizar la disponibilidad de los antirretrovirales, vigilar la calidad de los medicamentos que se proporcionan
- Acceso a los estudios de laboratorio necesarios para el monitoreo de los pacientes
- Capacitación y actualización del personal de salud responsable de la atención integral de los, y las, pacientes
- Programas de adherencia al tratamiento dirigidos a los pacientes, pero también a los familiares o personas cercanas a ellos que puedan apoyar en el proceso
- Servicios de atención que cumplan con principios éticos de no discriminación por motivos de raza, sexo, edad, ni orientación sexual
- Formulación de guías nacionales estándar para el manejo de los antirretrovirales
- Integración de registros confiables que nos permitan asegurar y evaluar las coberturas de pacientes con antirretrovirales.

Estos puntos pueden ser garantía mínima de calidad y cobertura de los tratamientos, de tal manera que se garantice el impacto suficiente en beneficio de las personas que viven con VIH/SIDA. En México ya estamos trabajando en todos ellos, con diferentes grados de avance. Recientemente, en México se han logrado cambios legislativos de trascendencia respecto a este problema de salud. Destaca la aprobación por el Congreso mexicano de una profunda reforma estructural que establece un seguro universal público de salud, que permitirá brindar, entre otras cosas, protección financiera a las personas con VIH/SIDA y garantizarles una atención integral.

Los países en desarrollo debemos reforzar las campañas de prevención, en especial aquellas dirigidas a los grupos poblacionales de mayor vulnerabilidad, campañas con mayor sensibilización social en el uso del condón y, al mismo tiempo, generar e instrumentar disposiciones y mecanismos legales que permitan disminuir el estigma y discriminación de las personas que viven con VIH/SIDA. La discriminación y el estigma son, en sí, una epidemia paralela a la del VIH, la cual debe enfrentarse con toda la fuerza de la razón, con la decisión y organización de los gobiernos, así como de las agencias y organismos internacionales.

El Congreso de México también expidió una ley que prohíbe y castiga todo tipo de discriminación, incluyendo la vinculada con la orientación sexual y las condiciones de salud.

Como parte de nuestra estrategia de vigilancia epidemiológica de tercera generación, que se basa en indicadores específicos, se hace un seguimiento puntual y una evaluación constante de los avances contra la discriminación y a favor de los derechos humanos. Asimismo, hemos iniciado el reforzamiento de las estrategias preventivas dirigidas a hombres que tienen sexo con otros hombres, usuarios de drogas inyectables y hombres y mujeres dedicados al comercio sexual, en estrecha colaboración con las organizaciones de la sociedad civil.

Permítanme aquí reconocer en México la participación entusiasta y constructiva de la sociedad civil y las personas que viven con VIH/SIDA en la definición e instrumentación de políticas públicas. La investigación en este campo también representa uno de los grandes retos. Es, por eso, que será sin duda, uno de los temas a abordar durante la Reunión Ministerial de Investigación que mencionó el Dr. Lee y que se desarrollará en México del 16 al 20 de noviembre de este año.

La respuesta ante los retos en la salud, requiere la participación de todos los sectores posibles, sean éstos los sectores gubernamentales, legislativos, sociales o privados. En México tenemos avances importantes al respecto, como lo muestra la ratificación el pasado 12 de abril, por parte del Senado de la República, del Convenio Marco para el Control del Tabaco y también la participación activa de la industria tabacalera en la implementación de las medidas regulatorias.

Permítanme felicitar la propuesta del Director General de dedicar el *Informe sobre la salud en el mundo 2005* a la salud de las mujeres. Es necesario renovar e impulsar iniciativas mundiales. Hoy es un mundo globalizado y lamentablemente las tecnologías no llegan a todos. Aún mueren más de medio millón de mujeres al día. Lamentablemente, doctor Lee, esas mujeres no pueden tener a alguien que venga a hablar por ellas a este foro.

Señor Vicepresidente de la Asamblea, señor Director General: deseo refrendar el compromiso del Gobierno mexicano de dar la batalla contra estos flagelos reconociendo, al mismo tiempo, la importancia de la cooperación regional e internacional. Ante los problemas globalizados, debemos dar una respuesta unitaria.

Dr SUJUDI (Indonesia):

I would like to take this opportunity to congratulate Dr Lee Jong-wook, Director-General of WHO, for his many achievements during his first year in office. His initiative to revitalize the primary health care concept as well as to introduce the "3 by 5" programme, for example, certainly will become milestones in improving the health status of people worldwide.

Entering the third millennium, Indonesia is facing many health problems as a nation. To cope with these problems, various activities have been conducted, including health sector reform. The main objectives of this reform are to reformulate the health development policy implemented in the country, as well as to strengthen the health delivery and financing system. In line with the new health development policy, the health development programme in Indonesia focuses on promotion and prevention activities, while the health delivery system that will be developed in Indonesia is based on the concept of primary health care, supported by a social health insurance scheme.

Using these new health policy development and health delivery and financing system approaches, many health programmes to combat common and new emerging diseases are being implemented. Eradication of poliomyelitis is just a matter of time, since there have been no new reported cases in Indonesia in the last decade. Efforts to control tuberculosis and malaria, as well as other infectious and communicable diseases, are still under way.

Indonesia has successfully developed a national strategic plan on HIV/AIDS. This strategy is now being implemented nationwide, and is supported by all stakeholders, including government, the private sector, nongovernmental organizations and communities. Several strategic measures such as building political commitment, strengthening community involvement, focusing on promotion and prevention, providing accessible, affordable and quality treatment as well as harm reduction activities have been conducted successfully. In spite of the many programmes and activities, the HIV/AIDS epidemic is still growing in Indonesia. It is reported that HIV/AIDS in Indonesia is being transformed from the "low-prevalence epidemic" which prevailed since 1999 into a "concentrated epidemic" in

certain provinces and groups. As the availability of funds is critical, Indonesia has submitted a proposal to The Global Fund to Fight AIDS, Tuberculosis and Malaria. It is of utmost importance for Indonesia that The Global Fund accepts and approves this proposal. As for the "3 by 5" initiative to guarantee the availability of affordable and quality antiretroviral drugs, it is our plan to produce this medicine locally. It is our hope that WHO will also support this plan.

I do hope that WHO will continue its support in providing technical assistance and guidance to member countries.

M. PETTIGREW (Canada) :

Monsieur le Président, Monsieur le Directeur général, distingués délégués, je suis très honoré de diriger la délégation canadienne à cette Assemblée mondiale de la Santé. Le Canada continuera bien sûr à travailler en collaboration étroite avec l'OMS et le Dr LEE Jong-wook, Directeur général, que je félicite pour son excellent discours d'aujourd'hui.

Le leadership de l'OMS est important dans la lutte contre le VIH/SIDA. La semaine dernière, le Canada a augmenté son engagement financier dans le cadre de cette lutte en apportant une contribution de 100 millions de dollars à l'initiative « 3 millions d'ici 2005 » et 70 millions au Fonds mondial de lutte contre le SIDA, la tuberculose et le paludisme. Le Canada et la population canadienne sont fiers de prendre ces mesures contre le VIH/SIDA. Ces contributions mettent en évidence le leadership de l'OMS, l'organisation de la santé la plus importante dans le domaine de l'établissement de normes de base et de normes techniques, de la formation des ressources humaines pour la santé concernant le VIH/SIDA dans les divers pays et du renforcement des capacités. Il s'agit d'éléments clés pour ralentir le rythme de cette épidémie et éventuellement l'enrayer. Nous encourageons fortement les autres pays à relever ce défi auquel l'humanité est confrontée.

La semaine dernière, une autre étape historique de la lutte contre le VIH/SIDA a été franchie lorsque le Canada est devenu le premier pays à promulguer une loi autorisant l'exportation de versions plus abordables de médicaments brevetés aux pays en développement. Les produits pharmaceutiques canadiens exportés respecteront les mêmes normes rigoureuses concernant l'innocuité, l'efficacité et la qualité que les produits fabriqués à l'intention des Canadiennes et des Canadiens. Ces produits pharmaceutiques prolongeront des vies, amélioreront la qualité de vie des personnes infectées par le VIH/SIDA et permettront aux enfants de rester avec leur famille plutôt que d'aller dans des orphelinats. Le VIH/SIDA est également une réalité pour bon nombre de Canadiennes et de Canadiens. En réponse à cette réalité, nous doublerons les ressources octroyées à la stratégie canadienne sur le VIH/SIDA au cours des cinq prochaines années.

J'aimerais également présenter dans leurs grandes lignes les liens entre le travail de l'OMS dans le domaine du VIH/SIDA et son action en matière de santé génésique et sexuelle. Il est inadmissible que, dans de nombreuses parties du monde, les besoins les plus fondamentaux en matière de santé génésique des populations ne soient pas satisfaits. Dans la réalité, cela se traduit par des taux inacceptables de mortalité et de morbidité maternelles d'infections transmises sexuellement, y compris le VIH/SIDA, et de grossesses non désirées, qui peuvent avoir des effets catastrophiques sur les femmes et les adolescentes ainsi que sur leurs enfants, la collectivité et les générations futures. La stratégie de l'OMS relative à la santé génésique et sexuelle est un outil indispensable pour relever ces défis. Elle représente aussi une contribution importante pour atteindre les objectifs du programme d'action du Caire et les objectifs du Millénaire pour le développement liés à la santé.

(L'orateur poursuit en anglais.)
(The speaker continued in English.)

The outbreak of SARS highlighted the need for increased multilateral cooperation in strengthening collective defences against communicable diseases. Our experience with SARS has led to a renewed emphasis on public health in Canada. Yesterday we announced the creation of a public health agency. A key role of this agency and its collaborating centres across Canada will be to link up with WHO and other international partners to strengthen disease surveillance and control networks.

Revising the International Health Regulations is a key element of international preparedness against global disease threats. Canada hopes that serious progress can be achieved.

Tobacco control will remain a priority for Canada. We have championed the WHO Framework Convention on Tobacco Control. Canada will want to be consistent with its own strategy on healthy living as well, which is quite reasonable and balanced. This is why we strongly support the draft global strategy on diet, physical activity and health.

Canada and the world need a World Health Organization that is strongly rooted in the principles of results-based budgeting and programming, promoting value-for-money and transparency. This Organization's products will only be as good as its governance and its management.

Canada is aware of its global responsibilities. We are committed to strengthening the World Health Organization and to working with you all towards a healthier world for all.

El Dr. GONZÁLEZ GARCÍA (Argentina):

Hace dos años estuvimos aquí en un momento muy difícil para mi país, tratando de recrear las condiciones de gobernabilidad necesarias para reencauzar a la Argentina. Quiero hoy agradecer a los países que nos ayudaron, a las instituciones que nos ayudaron, como la OMS y la OPS, y a todos los habitantes de esos países.

Hoy, bajo el gobierno constitucional el Presidente Néstor Kirchner estamos saliendo adelante, aunque la emergencia continúa. La Argentina está de pie y reconstruyéndose. Es verdad que nuestras preocupaciones son muchas y nuestros problemas también son muchos, pero nos obligan a tener una marcada atención, fronteras adentro de nuestro país. Pero no por eso dejamos de ver ni la región ni el mundo que nos rodea.

Estamos en un mundo cada vez más globalizado y esta globalización está modificando la naturaleza de los retos de la salud. Además de los problemas locales, los sistemas nacionales de salud deben afrontar de manera creciente la transferencia internacional de riesgos para la salud. Esta transferencia se asocia, entre otros procesos, a cambios ambientales globales, a movimientos poblacionales, al comercio regular y al comercio de productos dañinos legales, como el tabaco y el alcohol, y el comercio de productos dañinos ilegales, como las drogas.

La salud pública es un ámbito que presenta beneficios para todos, y es en ese ámbito donde es posible lograr mejores resultados a través de un trabajo conjunto entre los países. En este marco es necesario considerar la relevancia que tienen los aspectos medioambientales sobre el estado de salud de la población y resaltar en consecuencia la necesidad de abordar este problema global de manera conjunta entre los países.

La OMS ha estimado que alrededor del 25% de las enfermedades evitables en el mundo tienen su causa en la baja calidad del medio ambiente. Por esta razón, el Presidente Néstor Kirchner ha incorporado en el año 2003 la Secretaría de Ambiente y Desarrollo Sustentable a nuestro Ministerio de Salud: para optimizar la cooperación internacional en esta materia. Ello implica fortalecer la coherencia de las políticas sanitarias ambientales de cada país, implementar convenios ambientales globales, aunar criterios sobre la necesidad de consolidar un entorno de desarrollo sustentable a nivel global, y promover la investigación y la difusión de información sobre el medio ambiente.

La salud internacional, o salud global, es una función que toma trascendencia día a día dentro de nuestros ministerios de salud. En tal sentido, la misma debe ser incluida dentro de las funciones esenciales de salud pública que han sido postuladas por la Organización Panamericana de la Salud. Como ejemplo de esto hemos hecho una negociación regional de precios de antirretrovirales, que constituye un caso exitoso en cuanto a salud global. El mismo evidencia que la globalización puede constituir una oportunidad para el campo de la salud pública, pero que es necesario acompañarla con un apropiado fortalecimiento de nuestros ministerios de salud en relación a la salud global. En junio del año pasado nos reunimos en Lima los ministros de diez países: Argentina, Bolivia, Colombia, Chile, Ecuador, México, Paraguay, Perú, Uruguay y Venezuela. El objetivo general de esta iniciativa fue lograr un mayor acceso al tratamiento antirretroviral de las personas que viven con VIH/SIDA y al diagnóstico en los países de la región. Nuestra intervención en este proceso permitió que todos los países que participaron en la negociación hayamos obtenido menores precios, debido a que fue nuestro país quien presentó los precios más bajos en la casi totalidad de los medicamentos. Adicionalmente

cabe aclarar que la Argentina es uno de los pocos países de nuestra región donde el 100% de las personas que conviven con el VIH/SIDA reciben tratamientos absolutamente gratuitos. En este proceso hemos logrado que la región reduzca los precios hasta en un 90% para algunos antirretrovirales, y que, además, hayamos ahorrado en conjunto casi US$ 150 millones por año, lo que nos da la posibilidad de tratar a 150 000 pacientes más, también por año.

En el mismo sentido, en el contexto de las relaciones con los Ministerios de Salud del MERCOSUR, Bolivia y Chile, hemos aprobado acuerdos en materia de control y de ratificación de enfermedades inmunoprevenibles, políticas de prevención y control del dengue, capacitación conjunta en áreas como la vigilancia epidemiológica, y por supuesto políticas de medicamento conjuntas.

Por iniciativa de la Argentina también contamos ya con una comisión de salud y desarrollo del MERCOSUR, Bolivia y Chile, que mantiene una visión en común: invertir en salud para los más pobres, y en ese sentido nos enfrentamos en el marco del cumplimiento de los Objetivos de Desarrollo del Milenio.

Ante el quiebre del acceso a los medicamentos por la grave situación de nuestro país, hemos construido una política nacional de medicamentos que tiene en la ley de prescripción por nombre genérico su columna vertebral. Esto permitió que muchos medicamentos hayan reducido su precio en más del 80%; que más de 4 millones de personas que habían dejado de ir a la farmacia puedan comprar los medicamentos hoy; que la Argentina presente uno de los récords mundiales de prescripción por nombres genéricos: el 71% de las recetas se prescriben por nombre genérico y lo hemos obtenido en un plazo de 15 meses. Hemos implementado además un programa de provisión pública gratuita de medicamentos, que se llama «Remediar» y que cubre a 15 millones de personas en atención primaria, que reciben gratuitamente los medicamentos a través de todos los centros de atención primaria en nuestro país.

En un país federal siempre es difícil construir una política nacional. Sin embargo, desde hace un año comenzamos a trabajar en un Plan Federal de Salud, que será lanzado el 24 de mayo de este año por el Presidente. Este Plan contó con la participación de todos los actores.

Quiero decirles que en el 2002, cuando la Argentina atravesaba la peor crisis de su historia considerada por muchos como la peor crisis del mundo, tomamos la crisis como una oportunidad: no queríamos ser espectadores. Por eso fuimos actores y realizamos acciones. Soy un convencido de que en la vida no hay peor situación que la inacción. Por eso, y en función de considerar que la protección social en materia de salud es uno de los pilares de la política sanitaria de la Argentina, hemos logrado revertir la situación, hemos evitado el implacable impacto negativo sobre la salud de nuestra población, y eso se refleja en los indicadores de salud.

Durante 2002 trabajamos para que el colapso del país no se produjera, y como siempre pasa con la prevención, nadie da demasiado valor porque si es efectiva el problema no se produce. Creemos que hemos sido exitosos en ese momento al evitar ese colapso que amenazaba la salud de nuestro pueblo.

Por último, quiero decirles que hemos recuperado la voluntad política como fuerza de transformación creando un valor sanitario indispensable para el renacimiento argentino: mejorar la salud, combatir la pobreza, ampliar las capacidades nacionales para el desarrollo económico es el gran objetivo que nos convoca para generar mecanismos de acción, impacto y oportunidad de aplicación sobre todos los habitantes, pero principalmente sobre los más pobres. Como siempre digo, no hay peor pobreza que la falta de salud. Que los pobres sean ricos en salud es la primera conquista que reclaman los Objetivos de Desarrollo del Milenio.

The PRESIDENT:

I now give the floor to the delegate of Jamaica on behalf of the Caribbean Community, which comprises Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago and his own country.

Mr JUNOR (Jamaica):

Despite our small and varying size and socioeconomic status, we are countries with a history of cooperation and collaboration in health, social and political matters. Over the past 20 years we have endeavoured, through our Caribbean Cooperation in Health Initiatives, to address those priority health matters that are common to us all and which are best resolved through collaborative, subregional action. Yes, we have had some successes, but we are still confronted with major challenges. In general, the Caribbean territories are perceived as a group of fairly well-developed States with little or no need of external technical or financial assistance. Not so, Mr President. We are indeed a group of countries with populations ranging from approximately 4000 in Montserrat to over 8 million in Haiti. Significant parts of our population live below the poverty line. We are countries whose socioeconomic survival is dependent on several external factors and which are also from time to time affected by natural disasters. Our economies are built primarily around tourism, agriculture and financial services, all of which are under threat from various changes in global trading and financial service arrangements, the reduction in preferential considerations for developing States and the maintenance and increase in subsidies to some areas of agricultural production in the developed world. We are a group of both island and mainland countries with very mobile populations who travel throughout the region for trading, work, education, health services and vacation. Managing the challenge for health that mobility poses is further complicated by our primary economic activity, namely tourism, where thousands of persons visit our countries daily from all areas of the world travelling by air, land and sea. In this context it is essential for us to address our priority issues on a subregional basis, as disease transmission knows no boundaries. Today, as some of us host our brothers and sisters, refugees from conflict, it is necessary to mobilize resources to provide assistance to this vulnerable group. While we address their health concerns, we vigilantly maintain a heightened surveillance and take action to protect the health status of the host populations.

Despite our limitations, the Caribbean Health Programmes have been successful in creating an environment free of measles, poliomyelitis, congenital rubella and other vaccine-preventable diseases. We acknowledge the important contribution of the Pan American Health Organization and the World Health Organization and the benefits received from North-South and South-South cooperation. Most countries in our region are on target for achieving the Millennium Development Goals regarding the eradication of extreme poverty, achieving universal primary education, promoting gender equality and empowering women, as well as ensuring environmental sustainability. However, some indicators, such as those for improvement of maternal health and reduction of child mortality, are still very high and therefore will require major investments in order to achieve the goals set. It is anticipated that major investments will also be necessary in relation to health promotion; education, training and retention of staff; health information systems; and monitoring and evaluation mechanisms. The main burden of disease in our subregion is a result of the high prevalence of noncommunicable diseases, namely hypertension, diabetes, cervical and prostate cancer. About 25% of our population is affected by a noncommunicable disease and diabetes alone is costing our region over US$ 830 million on an annual basis. HIV/AIDS is also a major contributor to the burden of disease. With a prevalence of 2.6%, the Caribbean is globally the worst affected region after sub-Saharan Africa.

An integrated Caribbean regional strategic plan to combat HIV/AIDS was developed in the late 1990s and is being coordinated through the Pan-Caribbean Partnership Against HIV/AIDS. There are ongoing programmes towards reduction of stigma and discrimination and the promotion of legislation to protect those living with AIDS. We recognize the contribution of PAHO, WHO and Caribbean Epidemiology Centre (CAREC) and their support for the regional conference on antiretroviral treatment which was held last February. This conference enabled us to assess the current status of our national treatment programmes and provided the opportunity to share best practices and the latest developments in care and treatment. With support from several organizations, our region now has access to lower-priced antiretrovirals. International assistance continues to be crucial in our response to HIV/AIDS and on behalf of the Government and people of Jamaica, I thank the Secretary-General of the United Nations and the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria, as Jamaica yesterday signed a grant agreement for US$ 23 million over the next five years. Their support, together with the cooperation of the Clinton Foundation, will advance the

implementation of our national AIDS programmes. I also wish to extend thanks on behalf of the Organization of Eastern Caribbean States, Belize, Guyana, Suriname and the Pan-Caribbean Partnership, which have received confirmation of assistance from the Global Fund. These grants, in conjunction with funding from the World Bank and other partners, will enable us to expand and accelerate our HIV/AIDS programmes. However, in some instances, the smaller countries still have difficulty in dealing with the prerequisites, complexity and conditionality of the procurement processes.

In collaboration again with the Pan American Health Organization (PAHO), a regional strategic plan has been developed to address noncommunicable diseases and some initial activities have been organized to involve countries in developing a national policy and plan. With PAHO we are working towards incorporating the Caribbean Life Style Initiative (CARLI), a programme modelled after CARMEN and CINDY, programmes in Latin America and Europe respectively which address the behavioural aspects of noncommunicable diseases. The main challenge currently is the mobilization of additional resources in order to further implement and accelerate the programme for noncommunicable diseases. In addition, the Caribbean feels that continued access to affordable pharmaceuticals is being severely threatened by the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) that will provide lengthened protection of property rights to pharmaceuticals, thereby contributing to significantly higher prices for longer time periods. The TRIPS agreement can potentially undermine an adequate response to noncommunicable diseases and HIV/AIDS, simply because the prices of the required pharmaceuticals are not affordable. The flexibilities in the TRIPS agreement, such as compulsory licensing and parallel imports, are still to be proven. Our small economies do not possess the capacity to explore deeply these legally complicated processes. Hence, a regional effort with the support of PAHO and the World Bank may provide an opportunity to address the situation as of January 2005. We call on this Health Assembly to recognize these continuing difficulties and to support efforts to ensure access to affordable pharmaceuticals.

The Caribbean region needs urgently to upgrade and modernize its surveillance system in order to be able to detect early and respond to disease outbreaks and emerging diseases. It is in this respect that we welcome adjustments to the International Health Regulations, and embrace particularly the syndromic reporting requirements. This is relevant because of the high number of people visiting our region, intraregional travel and the threat of emerging infectious diseases. The support of PAHO and the Caribbean Epidemiology Centre has been invaluable in keeping our region free from SARS, which might have had a devastating effect on our tourism and economies. One of the effective measures was the development of the CARISERVNET, an electronic list server, creating a platform for communication and discussion for public health workers.

Another significant challenge is the retention of sufficient numbers of our trained personnel. We have faced in recent years the migration of our health personnel, especially nurses who are actively recruited by private and public organizations from developed countries, namely, the United States of America, the United Kingdom of Great Britain and Northern Ireland, Canada and the Netherlands. Significant numbers of our nurses leave the region annually and in the last three years we have lost more than US$ 25 million of our investments in the training and education of nurses. Dealing with this issue, we recognize, is a very difficult task, as people cannot be prevented from migrating. To address this situation will take time and resources. Health personnel, especially our nurses, are crucial in the response to the HIV/AIDS epidemic and noncommunicable diseases. We look forward to the debate and resolution of some of these issues in the Executive Board, as it still remains a critical element in the sustainability of our gains and the advancement of our future goals. As we in CARICOM continue to work together in collaboration with WHO, PAHO and other organizations to ensure the health of our people, we recognize the challenges of the coming years. We commit ourselves to strengthening our local and regional health institutions; widening our training and educational capabilities, including distance learning accessibility; implementing retention measures and managing the migration of skilled personnel; and to the acquisition and development of appropriate health information systems. We need to access more technical cooperation from WHO Member States.

I end with an old Caribbean exhortation, which I think it is appropriate to use here, "When all is said and done, let there be more done than said.".

Mr JOHANSSON (Sweden):

Every individual's right to a healthy life and public accessibility to health and medical care are vital for both the social and economic development of our countries. But ultimately, this also concerns respect for human rights. As governments, it is our responsibility to work for solidarity and justice. This means that we must design a health and medical care system that serves everyone. How health and medical care systems are designed and financed plays a crucial role in people's chances of receiving the care they need.

Advances in health care must reach everyone, not only the people who can afford them. Health care must therefore be governed by principles and objectives that are very different from those that apply in the market. A patient is not a consumer and health care is not a business deal between patient and care provider. The goal must be good health and medical care on equal terms for all citizens.

Health care systems that are accessible to everyone are superior both in terms of equity and efficiency. International experience tells us that universal systems are better able to control costs and better equipped to modernize and improve their services.

Working to make good health and medical care accessible to everyone requires increased cooperation between countries, with every individual country still controlling its own health care system. Cooperation is needed to enable better use of resources and the exchange of knowledge and experience. The World Health Organization has an important role to play in this.

I would like to make some specific comments on the future work of WHO. First of all, the issue of HIV/AIDS. As the Director-General clearly stated in his speech, the HIV/AIDS epidemic is the crucial issue for global development. The international community is facing enormous challenges and Sweden welcomes the leading role that WHO is now playing in the fight against HIV/AIDS. I would particularly like to draw attention to two factors that are crucial for success in the fight against HIV/AIDS. One, national ownership in the fight against the epidemic. Governments have to take the lead if we are to succeed. Two, health systems must be strengthened and actions at the country level must be well coordinated. HIV treatment for all who need it is very important to us and Sweden has already contributed almost US$ 40 million to The Global Fund. I am glad today to announce that Sweden will also give direct financial support to the "3 by 5" initiative. For 2004 the Swedish contribution will amount to US$ 5 million.

Second, the issue of sexual and reproductive health and rights. We strongly support the new WHO strategy on reproductive health. Universal access to sexual and reproductive health care and services is absolutely essential if we are serious about poverty eradication, gender equality and attaining these goals.

Third, the issue of diet, physical activity and health. Obesity is becoming one of the biggest global threats to public health. The consequences are great human suffering and elevated costs for already strained health care systems. A global strategy for diet, physical activity and health is indispensable. Sweden congratulates WHO on its excellent work in this area and would like to express its full support for the new draft. The WHO strategy is an important instrument for achieving cost-effective health gains in industrialized and developing countries alike.

Fourth, alcohol. We welcome the fact that alcohol issues are now being given higher priority in WHO's work. This is of great importance, given that alcohol constitutes a primary risk factor for diseases all around the world. In Europe alone, every year some 55 000 young people aged 15-19 die of alcohol-related causes and it is a growing problem in Europe.

Fifth, communicable disease control. WHO's initiative to propose a revision of the current International Health Regulations is very timely. There is an urgent need to further strengthen the global instruments to combat communicable diseases. It will be a challenge for WHO to meet the requirements of the International Health Regulations, while ensuring that it will also be able to develop the capacity to meet challenges outside the Regulations. Antibacterial resistance, for example, will continue to be a serious threat.

The establishment of a European Centre for Disease Prevention and Control is in the implementation stage and the Centre will be operational early next year. Sweden believes that this Centre, which will be located in Stockholm, will develop close collaboration with WHO.

Finally, WHO provides us all with a very good common platform for raising key health issues. A powerful health organization is essential to offer all citizens of the world better chances of living a healthy life.

The PRESIDENT:

Thank you, honourable delegate of Sweden, and special appreciation for the funds that have been given to support the "3 by 5" initiative.

Mr STARODUBOV (Russian Federation):
Г-н СТАРОДУБОВ (Российская Федерация):

Спасибо.
Уважаемый г-н Председатель.
Мы благодарим Генерального директора за представленный нашему вниманию доклад. Соглашаясь с его оценками весьма непростой ситуации в мире в области здравоохранения и выдвинутыми приоритетами в деятельности ВОЗ, мы подтверждаем свою готовность самым активным образом участвовать во всей этой работе.

Генеральный директор коснулся практически всего спектра программной деятельности нашей Организации. Мы хотели бы отметить три основных стратегических сегмента.

Первое. Достижение Целей тысячелетия в области развития в сфере здравоохранения мы рассматриваем как глобальную миссию ВОЗ в современных условиях. Такое целеполагание составляет саму основу повседневной деятельности Организации, учтено в программном бюджете, используется в практической работе по координации усилий государств-членов в борьбе с бедностью во имя здоровья и с неравенством в доступе к медицинскому обслуживанию. В итоге это будет способствовать достижению коренного перелома в осознании правительствами стран ключевого значения здоровья в обеспечении общественной безопасности и улучшении экономической ситуации.

Второе. Мы, безусловно, одобряем ориентацию ВОЗ на усиление ее деятельности непосредственно на страновом уровне - с особым акцентом на укрепление национальных служб здравоохранения и повышение дееспособности и эффективности. Именно улучшение ситуации в странах становится сегодня базовым критерием успеха деятельности ВОЗ в целом.

С этой целью представляется необходимым продолжить работу по оптимальному распределению ролей, компетенции и ответственности различных уровней нашей Организации: на уровне стран - оперативная деятельность, на региональном уровне - деятельность стратегическая, на уровне штаб-квартиры - установка и разработка нормативов, правил и стандартов.

Заслуживает внимания накопленный в Европейском регионе опыт работы на страновом уровне по индивидуальным планам на единой программной и бюджетной основе в формате двухлетних соглашений о сотрудничестве с государствами - членами нашей Организации.

Методологической основой такой работы может и должна стать адаптированная к современным условиям концепция первичной медико-санитарной помощи. Ее базовые принципы за прошедшие с Алма-атинской конференции годы только подтвердили свою жизненность и актуальность.

В этой связи мне хотелось бы призвать Секретариат усилить внимание к одной из важнейших форм работы со странами, причем во всех программных направлениях. Я имею в виду деятельность сотрудничающих центров и экспертов ВОЗ. С активным участием штаб-квартиры и Европейского бюро ВОЗ мы предприняли попытку оптимизировать этот сегмент сотрудничества в Российской Федерации. Совместно разработанные рекомендации могли бы инициировать развертывание этой работы на региональном и глобальном уровнях.

И третье. Мы убеждены в правильности выстроенных приоритетов в программной деятельности нашей Организации. Прежде всего мы в полной мере разделяем озабоченность Генерального директора серьезностью эпидемической ситуации в мире по туберкулезу,

ВИЧ/СПИДу и малярии. Поэтому мы поддерживаем Ваши меры, уважаемый Генеральный директор, по укреплению деятельности Секретариата в борьбе с этими заболеваниями.

Стержневой темой настоящей сессии стала борьба с ВИЧ/СПИДом. На наш взгляд, это совершенно оправданно и весьма своевременно, ибо именно сегодня ВИЧ-инфекция становится одной из основных преград для устойчивого социально-экономического развития.

Выдвинутая нашей Организацией инициатива "3 к 5" - это благородная и по настоящему амбициозная (в лучшем смысле этого слова) и, самое главное, достижимая по конечным результатам задача.

В решении этой задачи обязаны участвовать не только ВОЗ, ЮНЭЙДС и их партнеры. На наш взгляд, необходима практическая поддержка этой инициативы со стороны всех государств - членов ВОЗ, которые должны принять на себя обязательства, в том числе за счет собственных ресурсов, на национальном уровне.

Этот процесс и будет способствовать разработке и осуществлению национальных и региональных программ государств-членов по противодействию ВИЧ/СПИДу. В этом мы видим каталитическую роль инициативы для укрепления систем здравоохранения в целом.

Мы с удовлетворением отмечаем усиление роли экспертно-консультативной системы ВОЗ и предлагаем рассмотреть вопрос о создании специализированного технического Центра поддержки этого направления программной деятельности, а также об укреплении сети сотрудничающих центров по биомедицинским, клиническим, эпидемиологическим и социальным аспектам проблемы.

В этом отношении заслуживает внимания еще один весьма эффективный механизм работы единой системы ВОЗ по реализации стратегии "3 к 5". Я имею в виду механизм субрегионального и межрегионального сотрудничества. Совместные действия стран СНГ, а также аналогичные меры реагирования ряда других государств являются, на наш взгляд, перспективным инструментом международного взаимодействия, которые могли бы быть реплицированы на региональном и глобальном уровнях деятельности нашей Организации.

Уважаемый г-н Председатель.

Очень важно, что работа ВОЗ в странах и совместно со странами с учетом региональных и глобальных приоритетов, ее усилия по разработке национальных стратегий развития здравоохранения, а также техническая и гуманитарная помощь оставались для Организации стратегическими направлениями.

Решительно поддерживая выбранные ВОЗ приоритеты, правительство Российской Федерации в настоящее время рассматривает возможность внесения еще одного дополнительного вклада в Глобальную инициативу по ликвидации полиомиелита.

Мы с удовлетворением восприняли ее включение в повестку деятельности Организации на следующий год как одного из приоритетных вопросов, связанных с охраной здоровья матери и ребенка, и будем всячески помогать развивать деятельность в этом направлении.

В заключение еще раз позвольте выразить признательность г-ну Генеральному директору за представленный доклад.

Благодарю Вас за внимание, г-н Председатель.

The meeting rose at 18:50.
La séance est levée à 18h50.

FOURTH PLENARY MEETING

Wednesday, 19 May 2004, at 09:00

President: Mr Muhammad Nasir KHAN (Pakistan)
later: Mrs A. DAVID-ANTOINE (Grenada)

QUATRIEME SEANCE PLENIERE

Mercredi 19 mai 2004, 09h00

Président: M. Muhammad Nasir KHAN (Pakistan)
puis: Mme A. DAVID-ANTOINE (Grenade)

1. FIRST REPORT OF THE COMMITTEE ON CREDENTIALS[1] PREMIER RAPPORT DE LA COMMISSION DE VERIFICATION DES POUVOIRS[1]

The PRESIDENT:

The Health Assembly is called to order.

Today, the Health Assembly will consider the first report of the Committee on Credentials which held its meeting yesterday, under the chairmanship of Dr J. Larivière of Canada. The report is contained in document A57/37 which you have all received.

Does the Health Assembly wish to comment on the report? In the absence of any comments, does the Health Assembly agree to approve this report? I see no objection. The report is therefore approved.

2. EXAMINATION OF CREDENTIALS VERIFICATION DES POUVOIRS

The PRESIDENT:

In addition to this report, I have been informed by the Secretariat that, since yesterday's meeting, formal credentials have been received from Ghana, Romania and Tonga, Member States which had previously submitted provisional credentials, as is reflected in the Committee's report.

It has not been feasible to convene the Bureau to examine these formal credentials but, in accordance with previous practice, I have personally examined the formal credentials of these three

[1] See reports of committees in document WHA57/2004/REC/3.

[1] Voir les rapports des commissions dans le document WHA57/2004/REC/3.

Member States and have found them to be in keeping with the Health Assembly's Rules of Procedure. I would therefore recommend to the Health Assembly that Ghana, Romania and Tonga be accepted as having formal credentials.

Does the Health Assembly agree with this procedure? I see no objection. It is so decided.

3. INVITED SPEAKERS (continued)
INTERVENANTS INVITES (suite)

The PRESIDENT:

We will now resume consideration of item 4, "Invited speakers".

It is a great honour for me to welcome, on behalf of the Fifty-seventh World Health Assembly, Mr Jimmy Carter, former President of the United States of America, who has kindly agreed to address this Health Assembly.

Since he left the White House, Mr Carter has worked for more than two decades to forge partnerships to bring peace, health, and human rights to all people. In 2002, he was awarded the Nobel Peace Prize for "his decades of untiring effort to find peaceful solutions to international conflicts, to advance democracy and human rights, and to promote economic and social development.".

His Atlanta-based Carter Center – a non-profit-making, nongovernmental organization – has helped to improve life in more than 65 countries. A major component of that work has been on the ground in Africa, Latin America and Asia where The Carter Center has brought vision, leadership, and collaboration to major efforts to prevent and control disease. These include leading a worldwide partnership that has reduced guinea-worm disease by more than 99% since the disease was targeted by WHO in 1986 for eradication; helping to distribute more than 50 million drug treatments to sufferers of river blindness in Africa and Latin America; advancing the use of household latrines in Africa to reduce the spread of trachoma; working to diminish the stigma of mental illness and improve services for mental health care; and teaching small-scale farmers in 15 African nations how to double or triple their grain production.

Today, Mr Carter is here to share with us his vision for closing the gap between the rich and the poor in developing nations and to discuss lessons learned for the future.

On a personal note, I would like to thank him for the tremendous amount of work done in Pakistan. Since my appointment as a minister in Pakistan, I have often said that we need leaders like Jimmy Carter, Nelson Mandela and Martin Luther King. The world is in desperate need of leaders who share the same vision of peace and tranquility. This was shown during Jimmy Carter's presidency in the White House.

It is with great pleasure that I now invite Mr Carter to address this Health Assembly.

(Applause/Applaudissements)

Mr CARTER (former President of the United States of America):

I am grateful to Dr Lee for inviting me and my wife Rosalynn to participate in this impressive annual gathering of the world's ministers of health and their closest associates and partners. My wife attended this event in 1979 when I was in the White House, before I was involuntarily retired in 1980, but this is my first visit to the Health Assembly.

I want to share with you my conviction that the greatest challenge facing the world is the growing chasm between the rich and the poor, both among nations and people within nations. As you know, despite notable economic growth in many regions, one fifth of the world's people still live on less than US$1 per day – barely enough for food and shelter and leaving nothing for either education or health care. This disparity in wealth is growing in parallel with vast improvements in communications, so that the poor are increasingly aware of their relative poverty and of the world's

apparent indifference to their plight. This arouses among them a sense of neglect, hopelessness and understandable resentment against the powerful and wealthy who are indifferent.

It has long been known that poverty is a key risk factor in illness. François Rabelais, a physician in the sixteenth century, described someone as "subject to a kind of disease ... called lack of money.". We now have the proof: decreases in levels of income are accompanied by increases in morbidity and mortality – and vice versa. How do we address this issue? I am here today because I believe that one of the most effective ways of closing this gap is for us rich people – and I include everyone in this room – to become more aware of their plight and committed to improving the health of the world's poor. This will bring great economic benefits to them and to us. It will also advance human rights and reduce violence. As stated in the International Covenant on Economic, Social and Cultural Rights, and I quote, "[we] recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.". This is an old story. Edmund Burke pronounced, and I quote him, "The public interest requires doing today those things that men of intelligence and goodwill would wish, five or ten years hence, had been done.". This was 250 years ago! Our relatively slow progress in reaching this goal shows how difficult are the challenges we face but, thankfully, our generation has unique and unprecedented opportunities to succeed. We have more scientific tools and social skills, and a better understanding of diseases and ways to prevent and control them – and even to eradicate a very few. This generation also benefits from unprecedented partnerships with enlightened industrial firms such as Merck, DuPont, GlaxoSmithKline, BASF and Pfizer, all of whom work with us at The Carter Center, as well as the enormous generosity of the United Nations Foundation and the Bill & Melinda Gates Foundation.

I envy you ministers of health and your associates your opportunity to serve in these times with the advantages provided by modern science. I believe your – our – biggest challenge is not necessarily inadequate resources, or insecurity. The biggest challenge is to define clearly the future we want in order to mobilize political will at the highest levels. As Lewis Carroll wrote in *Alice's Adventures in Wonderland*, "If you don't know where you're going, any road will get you there.". You health leaders must know, and make sure that all of us know, exactly where we want to go. We make extraordinary progress when we finally target a disease for total eradication. Just look at the incredible progress we made in eradicating smallpox more than 25 years ago and, more recently, the dramatic reduction in poliomyelitis and guinea-worm disease. There is no inherent reason why this should be true. The same techniques of team work and specific goals can and should be used to help ensure measurable improvements – I would say dramatic improvements – in all public health services, including for diseases like malaria and HIV/AIDS. We actually have an increase in recent years in incidence and deaths from malaria, and we know the devastation of AIDS. To marshal the crucial involvement of political leaders and donors, and the world's public, reports and appeals from ministers of health must be based on clear and quantifiable information about individual nations, not just collective data that are very disturbing but too general in nature. These should include specific goals to be reached: for instance, periodic and accurate measurements of progress (or lack of progress) in the number of babies infected with HIV at birth, children immunized against diseases, tuberculosis patients under treatment, deaths because of malaria, pregnant women who receive prenatal care and family planning information, and the number of public announcements in a country – as blatantly frank as possible – about the cause of HIV/AIDS and what preventive steps can be taken, including the use of condoms.

Political leaders and the general public must know – from you – about goals that have been met, achievements that have been realized, and be able to share in the credit and the celebrations of victory. They must also be assured of full accountability and the effectiveness of resources that are being expended, and the most urgent needs for additional funding – everything very specific. These specific reports – not just from a nation but also from the families and villages – are the most badly needed and the most persuasive. We have the challenge of inspiring political leaders (who quite often have thousands of responsibilities on their desks) and potential donors (who also receive multiple requests) to make that vision of better health care their own vision.

You all know that health is affected by many things that are not always considered a part of the traditional portfolios of you ministers of health. You need to be interested and involved in many of these additional things, such as family planning, education (especially of girls), debt relief, fair terms of trade, alleviation of poverty, democratic reforms, the plight of millions of children orphaned by

AIDS, and much more, many more things. Why should you be so interested in these other things? In order to use your perspective on health as a catalyst for all aspects of society to be marshalled in improving health.

At The Carter Center, we see our real health work in this broad context. Our motto is, and I quote, "Waging peace, fighting disease, building hope". We realize that with only 150 employees and a budget of about US$ 35 million a year, which we must raise for both health and peace, we can only do so much. (It is not an accident that more than two thirds of our resources are devoted to health.) We select projects based on the potential for significant impact, their relative neglect, where we believe interventions are doable, and which are amenable to a specific, data-driven approach – within individual homes and villages, and quite often to the individual person in a village that is endemic. We do not believe in duplicating the work of others, but we value our partnerships with you ministers of health, with the World Health Organization, and with many others. We emphasize action and achieving specific and measurable results. We are willing to take on difficult tasks and accept the possibility of potential failure. In literally thousands of individual villages that we go into, we have learned that with the modest outside help we give and some advice to village leaders and people who live there, people can and will take effective action to improve their own lives. By means of the International Task Force for Disease Eradication, comprising a dozen notable health experts (including a representative from WHO), we are regularly assessing all human illnesses and taking advantage of new discoveries and understanding to promote total control of a specific targeted disease. For instance, we are helping the governments of the six remaining endemic countries in Latin America to eliminate onchocerciasis once and for all, and I am looking forward to meeting with those health ministers later on today. We are also working with the ministers of health of five African countries and with the African Programme for Onchocerciasis Control to help control river blindness. Lions Clubs International is a major partner with us in this work, and we recently received a major challenge grant from the Bill & Melinda Gates Foundation for onchocerciasis work in the Americas. Last year, The Carter Center celebrated, as the President has said, the fifty-millionth cumulative treatment for river blindness that we have delivered into the mouths of people directly, in 11 different countries.

In two states of Nigeria, we are helping to demonstrate how interventions against lymphatic filariasis and schistosomiasis can be combined with our ongoing activities to control onchocerciasis. (We are still awaiting results of WHO-sponsored studies to confirm the safety of simultaneous administration of the three anthelminthic drugs for those three diseases and I hope that this decision by WHO will be made very soon.) In the fight against trachoma, we are emphasizing work on hygienic and environmental interventions in six African countries, with support from the Conrad N. Hilton Foundation and Lions Clubs International Foundation. Since 1997, we have also been helping the faculties of five Ethiopian universities at the specific request of the Prime Minister. We are training staff for more than 500 government-sponsored health centres that will serve rural populations in preventing and treating common diseases throughout Ethiopia.

The world health report 2001 described the tremendous magnitude and burden of mental illnesses around the world. Currently – and listen to this – mental illnesses account for five of the 10 leading causes of disability for people 15 to 44 years old, and by 2020 depression will be the second leading cause of all disability in the world. Of the 1.6 million violent deaths in the world annually, including homicides and all casualties of war, almost half of the total are suicides. The tragedy is that a variety of effective treatments are now available for all mental illnesses but most people do not have access to these treatments. My wife Rosalynn has been one of the most persistent advocates for mental health for the last 30 years, both in the United States and in other countries. She chairs the International Committee of Women Leaders for Mental Health, including female Heads of State, First Ladies, and members of royalty (several queens) who join their interest in promoting mental health in their countries and reducing the stigma surrounding mental illnesses. Crossing all national boundaries, stigma remains the most pervasive barrier to people receiving appropriate mental health services. While in Geneva on this trip, Rosalynn will speak at the technical briefing for ministers and their staff on the resolution passed at the Fifty-fifth World Health Assembly endorsing the Mental Health Global Action Programme, or Mental Health GAP. The time is long past for the world to focus its attention on these terrible but highly treatable diseases.

Finally, The Carter Center has worked intensively since 1986, in partnership with the Centers for Disease Control and Prevention, UNICEF, WHO, and many others, to help ministries of health and thousands of village volunteers, in more than 23 000 villages, reduce the incidence of dracunculiasis (guinea-worm disease) from an estimated 3.5 million cases when we began, to less than 33 000 cases last year – a reduction of more than 99%. Thirteen of the original 20 endemic countries are now free or almost free of the disease: eight countries have no disease, and five have less than 100 cases, some just a handful. Ninety-two per cent of the remaining cases are in Ghana, Mali and Sudan. Dr Lee and UNICEF Deputy Executive Director Kul Guatam joined me in a productive visit to Ghana in February of this year, where we met with President Kufuor, the Minister of Health Dr Afriyie and many others, and visited an endemic region. President Kufuor promised that Ghana would redouble its efforts to complete the eradication of dracunculiasis, having fallen far behind other countries in making progress on this disease. I also visited Togo and Mali and discussed the residual guinea-worm problem there. The most important obstacle to completing the eradication of dracunculiasis or guinea-worm now, of course, is the war in Sudan, and the prospect for a peace agreement there is very real. Sixty-two per cent of all the world's remaining cases are reported from Sudan's southern states. I am looking forward to meeting with the ministers of health from the 12 African countries in which the disease is endemic, to discuss the final obstacles to the eradication of guinea-worm and ways to overcome them. Before ending, I want to pay profound tribute to the roles played in the struggle to eradicate dracunculiasis by two people: President Amadou Toumani Touré of Mali who since 1992 has worked among the francophone countries; and, for the past six years, the former Nigerian Head of State General Yakubu Gowon. They exemplify the commitment we need from other political leaders in order to win in the struggle against guinea-worm, AIDS, malaria, tuberculosis, poliomyelitis, measles and many other preventable diseases.

Beyond some of our own health activities that I had time to mention here, I have helped where I could and I am still eager to help, taking advantage of my access to the world's news media and directly to Heads of State and other leaders in support of efforts to eradicate poliomyelitis and to control HIV infections in Africa. All of us at The Carter Centre stand ready to continue with you as partners in our common struggle to achieve better health for all. That is a notable commitment: I pledge my support to you as a partner.

(Applause/Applaudissements)

The PRESIDENT:

Thank you, Mr Carter, for your very enlightening and encouraging words. Your advice to close the gap between rich and poor is critical. We thank you for bringing hope to the world. I also thank Mrs Rosalynn Carter for being here today and doing tremendous philanthropic work in the world. On behalf of the Health Assembly and the Director-General, I thank you warmly for having honoured us with your presence.

This concludes consideration of item 4 of the agenda.

4. **ADDRESS BY THE DIRECTOR-GENERAL** (continued) **ALLOCUTION DU DIRECTEUR GENERAL** (suite)

The PRESIDENT:

We shall now resume our discussion on item 3 of the agenda.

I give the floor to the distinguished delegate of Ghana who will speak on behalf of the members of the Economic Community of West African States: Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Gambia, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, Togo and on behalf of his own country.

Dr AFRIYIE (Ghana):

The Member States of the West African Health Organization would like to congratulate the Director-General for the able manner in which he has been directing the World Health Organization since he assumed office. He is gradually evolving his own style and beginning to reach out to the underprivileged and high risk groups, taking serious cognizance of their health needs and giving them a platform to articulate their interests and vision. His "3 by 5" initiative is a case in point. Such pragmatic approaches need to be commended.

We in the West African subregion continue to face the dreaded scourge of HIV/AIDS. Although the prevalence rate of the disease in our subregion is not as high as in other subregions in Africa, nevertheless we are not being complacent. The disruption of normal life and activity in some countries, due to civil strife, makes it more important that we be on our guard in combating the disease. Our Member States have all embarked on preventive measures in order to limit the spread of the disease. The political commitment of our highest authorities has been obtained and we are all engaged in pursuing the goals of the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. We continue to face difficulties in making antiretroviral drugs accessible and affordable to our people, but do expect that the initiative we are developing for our subregion, to make treatment and care available to our people, will be given full support by WHO and other international partners. We fully endorse the Director-General's "3 by 5" initiative. We are also addressing, concomitantly with HIV/AIDS, the problem of tuberculosis, which has become more serious in states that have experienced or are experiencing civil strife. We call on the Global Fund to Fight AIDS, Tuberculosis and Malaria to continue to support the actions of our Member States to reduce the prevalence of these diseases in our subregion. Malaria continues to be critical to the health of our people, especially the under-fives and pregnant women, for who morbidity and mortality figures continue to be high. Our states continue to promote the use of impregnated nets and new efficacious treatment regimens, especially in chloroquine-resistant areas. We again call on our international partners to support our efforts in the implementation of our Roll Back Malaria programmes.

Maternal and infant mortality remain high in the subregion, despite the availability of well-defined strategies to address the problem. We in the West African subregion are developing a strategy to address the problem subregionally. We are aware that what are lacking are practicable approaches that can be applied in the subregion. We are demonstrating the will; we now need everyone's support. We strongly back the WHO Regional Office for Africa's new road map being developed for the reduction of maternal and infant mortality in Africa. Communicable diseases continue to plague our subregion. There is a need for continued collaboration to ensure that vaccine-preventable diseases, especially poliomyelitis and tetanus, are eradicated from the subregion. We commend WHO for the efforts being made regarding integrated disease surveillance. Resurgent epidemics in the subregion have increased the burden of disease. More efforts are, however, needed to control such epidemic diseases as yellow fever, Lassa fever and cerebrospinal meningitis, particularly serotype W135. The availability and affordability of vaccines are vital for the prevention and eradication of these diseases with high fatality rates, and we call on WHO and international partners to support our prevention programmes. The incidence of noncommunicable diseases continues to rise within the subregion and the complications associated with them are contributing significantly to the disease burden. Diabetes, hypertension and malignancies are steadily increasing. Diseases from occupational hazards and environmental pollution, especially from pesticides, are now an additional burden. Better screening methods and preventive interventions are needed to decrease the incidence of these noncommunicable diseases. In states that have recently experienced or are experiencing civil strife, the problem of mental health and the attendant drug abuse, especially among the young, constitute an additional burden that needs to be addressed urgently before it becomes unmanageable. The support of WHO is needed to address this growing problem in our subregion. Nutritional problems, especially vitamin and mineral deficiencies, continue to be a major public health problem, preventing our people from reaching their physical and mental potential. We are now aware of the problems in our subregion and are beginning to address the issues, as our knowledge about the nature and scale of the deficiencies increases. We hope to address the problems in an integrated and comprehensive manner. Some of our Member States have achieved a high level of salt iodization, for example. We look forward to the elimination of

vitamin and mineral deficiencies, implementing solutions that are already available and reaching the poorest and most remote populations in our subregion.

Our Member States are constantly being faced with the issue of "brain drain", which has severely affected health care delivery and national development goals. States have difficulty in retaining their health workers. The main reasons have been identified and some of our states are now taking steps to address these. The international community needs to complement our efforts to strengthen training and research institutions locally, so as to improve working conditions, to encourage job satisfaction and motivation and to create career structures for all professional health staff. We are also encouraging intercountry exchange of health workers as a means of fostering integration in the subregion. The need for adequate funding of health is urgent. The health sector is facing various demands to support health care services, including quality care in hospitals, and to ensure availability of human and material resources, as well as equitable distribution of care and services. Governments are being asked to increase their budget allocation for health, in line with the Abuja Declaration. Our states must continue to find ways to fund programmes and services, while encouraging other partners, nongovernmental organizations and international donors to provide long-term support. Not much can be achieved unless adequate funding is obtained, in order to have an impact on our very poor health indicators. The time to act is now and we encourage everyone to join us in our effort to ensure the highest possible standard of health for all our peoples in the West African subregion.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland):

In responding to Dr Lee's address, we would like to pay tribute to his leadership, his focus on the world's health problems and the inspirational words in his address yesterday. We also associate ourselves with the comments made by the European Union Presidency.

The United Kingdom of Great Britain and Northern Ireland welcomes the leadership shown by WHO on HIV/AIDS in launching the "3 by 5" initiative with UNAIDS. The United Kingdom is committed to improving the treatment for those living with HIV/AIDS, as well as improving the effectiveness of action to prevent the spread and impact of this devastating illness. The United Kingdom was the first country to commit funding for the "3 by 5" initiative. The initiative's success will now depend on progress in strengthening health care systems, on ensuring equitable access to treatment and on effective partnerships between WHO and others. In this connection we welcome the draft strategy and resolution on reproductive health, given the importance of and the strong links between reproductive health services and successful action in combating HIV/AIDS. Reproductive and sexual health services are vital also to the efforts to lower maternal and child mortality. We seek to work together internationally to tackle the HIV/AIDS pandemic. The United Kingdom is continuing to explore ways of improving care and treatment for its own citizens who are HIV-positive. In July we will be setting out further ways in which we intend to take this forward, including the United Kingdom's on-going financial commitment to international efforts.

The United Kingdom also welcomes the leadership shown by WHO on noncommunicable diseases and particularly the draft global strategy on physical activity, diet and health. International collaboration will be important here, too, to tackle the heavy burden of noncommunicable diseases, a growing challenge for public health across the world.

Returning to the field of communicable diseases, the SARS outbreak last year demonstrated what can be achieved with strong leadership and coordination from the World Health Organization. Containing the spread of this new disease was a remarkable achievement which, once again, proved the value of international collaboration on health issues. We need to use this new focus to look at other likely health threats from the communicable diseases field, in particular the potential for a new influenza pandemic. This is at the top of the priority list at the moment and should be one our main concerns. We have been pleased to contribute to WHO's thinking in this field and have been working with others to try to put in place the measures necessary to reduce the impact of an influenza pandemic, should one occur.

The United Kingdom has also been a major contributor to the Global Polio Eradication Initiative. We hope to see continued progress on this with the final push towards global eradication.

We welcome the consultation on International Health Regulations. We think this is a most important initiative which needs to move forward very quickly. We noted Dr Lee's comments yesterday about the importance of biosecurity in laboratories, relevant to SARS but also much more widely relevant and again an area where action needs to be taken at the earliest possible opportunity.

In collaborating more closely, we also need to respect the needs of each other's health care systems. The United Kingdom takes very seriously the concerns expressed by Commonwealth health ministers in Barbados at the loss of health care professionals to other countries. The United Kingdom was the first developed country to make a commitment not to recruit actively from developing countries. We will only do so where a country has a surplus of health care professionals and where there is a clear need and agreement at government-to-government level. In 2001, the United Kingdom published a Code of Practice to ensure fairness and transparency in dealing with overseas applicants. We will continue to look at ways to strengthen its operation and to react to concerns and criticisms as they arise. The United Kingdom Department of Health has agreements with a number of developing countries where the focus is on workforce capacity building, sharing and disseminating good practice. This includes a Memorandum of Understanding signed with South Africa last October which provides for shared learning opportunities and for reciprocal time-limited placements in each other's country. These measures confirm the seriousness that the United Kingdom attaches to this issue.

Finally, I should like to acknowledge the importance that WHO and its Member States are now giving to patient safety. Patient safety is a major international health care issue: when it is ranked in the global ranking of disease burden (which it is not yet), we will see that it ranks very, very high in the league table of international health problems. The financial cost to both developed and developing health care systems from these failures is enormous. It is therefore important that since the Fifty-fifth World Health Assembly passed the resolution on patient safety, a very active programme of work has been going on with Member States and with technical experts under the overall leadership of the World Health Organization. The United Kingdom is particularly pleased that the World Health Organization is intending to launch an International Alliance for Patient Safety and you will be hearing more about this in the technical briefing tomorrow.

In conclusion I would like to extend my warm wishes for a Health Assembly that will make positive steps in taking forward international progress in health – progress that is fundamental to every human being on our planet.

The PRESIDENT:

Thank you, honourable delegate of the United Kingdom of Great Britain and Northern Ireland. I also thank you for being the first to fund the "3 by 5" initiative.

Mr CONSTANTINIU (Romania):

On behalf of Mr Brînzan, the Minister of Health of Romania, I am particularly pleased to address the Fifty-seventh World Health Assembly on one of the main challenges confronting humankind in the twenty-first century: that is, combating HIV/AIDS. The HIV/AIDS epidemic is a daily subject in the international mass media. The approach is sometimes sensation-oriented, but it stems from the cruel reality that millions of hopeless human beings are condemned to misery and despair because of HIV/AIDS. The absence of hope is one of the worst consequences of HIV/AIDS in the most affected countries. At the same time, HIV/AIDS is a real danger for the economic and social development of these countries and cannot be tackled efficiently on an individual basis. The pandemic is a matter of concern and joint responsibility and action for governments, civil society, the private sector and the international community at large. Strong political will is essential in order to eliminate the obstacles such as ignorance, discrimination and lack of resources which are jeopardizing the impact of national and international efforts. Combating HIV/AIDS has over the past decade become a priority of the United Nations and a commitment enshrined in the United Nations Millennium Declaration as one of the Millennium Development Goals. Romania commends and is deeply involved in the United Nations' efforts aimed at combating HIV/AIDS.

Romania has taken very seriously the challenges of HIV/AIDS at the national level. Confronted in the early 1990s with the problem of a large number of children infected with HIV/AIDS, the Romanian authorities have undertaken sustained measures to improve the situation. I am pleased to inform you of the substantive progress achieved by Romania in this area, particularly over the past years. We have managed to decrease the incidence of paediatric AIDS cases almost tenfold in the last decade and nosocomial transmission has been eliminated. Romania has taken important steps towards specific and comprehensive legislation regarding universal access to treatment, as well as the social aspects such as stigma, discrimination and social integration of infected and affected persons.

The budget allocated to treatment has been increasing since 2001, when the budget was doubled to US$ 20 million, reaching the amount of US$ 30 million in 2003. Furthermore, in 2003 a multisectoral commission to fight against HIV/AIDS was set up, under the coordination of the Prime Minister. Its objective is to integrate and coordinate the efforts of government and civil society, as well as the international support to affected persons. This commission is a major partnership forum and ensures that all national efforts are coordinated and in line with national priorities.

The grant agreement with the Global Fund to Fight AIDS, Tuberculosis and Malaria, signed in June 2003, allows Romania to continue its commitment almost exclusively to prophylactic activities for HIV/AIDS through different projects. The budget allocated to these projects accounts for US$ 20 million, out of which US$ 16 million is devoted to prevention projects. In the HIV/AIDS national strategy for the forthcoming three years, we set as a major national goal to keep the incidence of HIV in 2007 at the level registered in 2002. There will be particular focus on continuing and expanding the partnership with nongovernmental organizations and the private sector. Addressing HIV/AIDS is not an insurmountable problem. We can break the vicious cycle of disease through solidarity and common action by all governments, civil society and the international community, as well as through the allocation of adequate resources and the use of innovative and effective approaches.

In conclusion, allow me to express my conviction that the debates will continue to push forward our joint campaign against HIV/AIDS. I also wish to convey Romania's appreciation and full support for the leadership of WHO in providing a framework of action likely to further enhance cooperation in combating HIV/AIDS around the world.

The PRESIDENT:

Thank you very much, honourable delegate of Romania. We agree with you that bringing hope to the victims of HIV/AIDS is the biggest thing we can give to the patients.

M. FAESSLER (Suisse) :

Monsieur le Président, Monsieur le Directeur général, Mesdames et Messieurs les Ministres, Mesdames et Messieurs, j'aimerais tout d'abord féliciter le Président à l'occasion de son élection à cette haute fonction et remercier le Directeur général et son équipe pour l'excellent travail accompli et leur engagement en faveur de la santé dans le monde. En tant que représentant du pays hôte de l'Organisation mondiale de la Santé, c'est un grand honneur et un plaisir pour moi de me trouver parmi vous.

Il y a quelques années nous pensions vaincre le fléau des grandes épidémies grâce au développement économique et à l'amélioration des conditions de vie. L'apparition du SIDA nous a toutefois montré une autre réalité. Ces dernières années, le SRAS et l'ampleur prise, par exemple, par un problème comme celui de l'obésité nous ont définitivement montré à quel point nous devons rester vigilants. Nous devons collaborer dans la lutte contre les maladies qui représentent une menace pour la santé et la prospérité.

Quel est le rôle de l'Etat et de la communauté internationale dans ce contexte ? L'Etat et les organisations internationales ont un rôle subsidiaire. C'est l'individu qui doit en premier prendre ses responsabilités. Mais nous devons créer les conditions-cadres permettant aux individus d'assumer leurs responsabilités. Je pense notamment aux efforts à faire dans le domaine de l'éducation, de

l'information, de la sécurité individuelle et collective ainsi qu'à l'établissement de bonnes conditions socio-économiques.

Cette approche s'applique à trois thèmes traités par cette Assemblée : le SIDA, l'obésité et les systèmes de santé. Pour le SIDA, l'éducation et l'information sont primordiales dans la prévention en Suisse. Nous avons été touchés très tôt par l'épidémie : dans les années 90, quelque 800 nouveaux cas de SIDA étaient enregistrés chaque année en Suisse. Grâce aux mesures que nous avons prises dans le domaine de la prévention et de la thérapie, ce nombre s'est réduit à quelque 200 nouveaux cas par an. Malheureusement, nous observons ces trois dernières années une recrudescence de nouvelles infections qui s'explique surtout par un faux sentiment de sécurité, dans la population homosexuelle notamment. Sur le plan national, nous continuons nos efforts. Nous encourageons la population en général et les groupes cibles particulièrement exposés à utiliser des mesures de protection, comme le préservatif ou des seringues propres. Sur le plan international, l'éducation et l'information sont tout aussi importantes. Pour atteindre les buts de l'initiative « 3 millions d'ici 2005 », nous devons intensifier et coordonner nos efforts. En tant que spécialiste des systèmes de santé, l'OMS doit mieux encore jouer son propre rôle aux côtés de l'ONUSIDA, du Fonds mondial, des aides bilatérales et naturellement des principaux responsables, les gouvernements et la société civile. La Suisse veut aussi apporter sa pierre à cet édifice. En tant qu'Etat hôte, mon pays est heureux de pouvoir apporter une contribution concrète pour remédier au besoin urgent de bureaux dont souffrent actuellement l'OMS et l'ONUSIDA à Genève. Le Parlement suisse va en effet octroyer un prêt sans intérêt de presque 60 millions de francs pour financer la construction d'un nouveau bâtiment administratif. La construction va démarrer bientôt.

Monsieur le Président, le rôle subsidiaire de l'Etat est aussi important dans la lutte contre l'obésité. Depuis de nombreuses années, la communauté internationale collabore contre la malnutrition et doit continuer de le faire. Les risques de santé dus à une mauvaise alimentation et au manque d'activité physique représentent un défi important. Même si la Suisse n'est pas parmi les pays les plus touchés par l'obésité, les tendances sont inquiétantes. Actuellement, presque un tiers des adultes en Suisse ont du surpoids. Le problème touche aussi de plus en plus d'enfants. C'est pourquoi mon pays soutient la proposition de Stratégie mondiale pour l'alimentation, l'exercice physique et la santé. Cette proposition tient compte de la primauté de la responsabilité individuelle en ce qui concerne l'alimentation équilibrée et l'activité physique. Cette proposition favorise les conditions-cadres permettant aux individus de faire les bons choix. L'éducation et l'information sont primordiales. Mais il s'agit également de créer les conditions favorables à la collaboration et au dialogue entre les Etats, l'industrie, les producteurs et les consommateurs.

Quant aux systèmes de santé, enfin, nous nous retrouvons dans le même contexte de partage de responsabilités individuelles et étatiques. La semaine dernière, mon pays a participé à la première conférence des ministres de la santé de l'OCDE. Nous avons débattu du défi que représente la viabilité financière de nos systèmes de santé. Une pure approche de libre marché n'est pas adaptée en raison des particularités du système de santé. Il demande un rôle de l'Etat plus important que dans d'autres secteurs du fait de l'asymétrie de l'information entre patient et soignant. Malgré cela, je crois qu'il faut introduire des éléments de marché là où ils peuvent être utiles. Le défi est de maîtriser les coûts tout en gardant l'accès à des soins de qualité. A l'OCDE, nous étions d'accord pour dire qu'il n'existe pas de système de santé idéal, car il dépend fortement de son développement historique et du contexte politique. Nous pouvons toutefois beaucoup apprendre en échangeant nos expériences. Nous progresserons en comparant les mesures qui ont bien fonctionné et celles qui n'ont pas apporté les effets désirés. C'est pourquoi la Suisse va demander à l'OCDE et à l'OMS d'analyser conjointement son système de santé avec ses forces et ses faiblesses.

Monsieur le Président, je vous souhaite plein succès dans les importants travaux de cette Cinquante-Septième Assemblée mondiale de la Santé.

Je vous remercie de votre attention.

The PRESIDENT:

Thank you, honourable delegate of Switzerland. We all want to thank you and Switzerland for the warm hospitality that we have received here. We also take heed to enhance our efforts to control diseases and to focus on diet and physical activity.

Professor CHATTY (Syrian Arab Republic):

الأستاذ محمد إياد الشطي (الجمهورية العربية السورية):

السيد الرئيس، السيد المدير العام، السيدات والسادة رؤساء وأعضاء الوفود المحترمين، السلام عليكم،

يشرفني أن أنقل لكم تحيات رئيس الجمهورية العربية السورية الدكتور بشار الأسد، مع تقديره العالي للمهام الإنسانية التي تتصدى لها منظمة الصحة العالمية، كما أتقدم بالتهاني إلى السيد الرئيس والسادة نواب الرئيس ورؤساء اللجان على الثقة التي أولتهم إياها الجمعية.

لقد استعرض وفد بلادي أنشطة المنظمة في الفترة الماضية، ونود أن نعرب عن تقديرنا للبرامج والخطط والمتابعة التي بدأنا نلمسها من المدير العام الدكتور لي وأعضاء إدارته ونتمنى لهم النجاح والتوفيق. والشكر موصول للمدير الإقليمي لشرق المتوسط الدكتور حسين الجزائري ولجميع العاملين في المكتب الإقليمي الذين يدأبون على تطوير الخدمات الصحية لبلدان الإقليم كافة.

السيد الرئيس، الحضور الكريم، يحقق قطاع الخدمات الصحية تقدماً وتطوراً ملموسين في بلدي سورية، ولقد أولت جميع الجهات المعنية اهتماماً كبيراً للمواطن في مناحي الحياة كافة من حيث صون صحته والاعتناء بطعامه وكسائه وعناصر البيئة بالإضافة إلى تعليمه وتدريبه.

تعتمد استراتيجية الصحة في سورية على تنمية الموارد البشرية والتوسع في الرعاية الصحية الأولية بشكل خاص والولوج إلى أعماق الريف تحقيقاً لمبدأ العدالة معتمدين في ذلك على مجمل برامج رائدة منها برنامج القرى الصحية الذي يكرس مبدأ مشاركة المجتمع في تحقيق الأهداف التي تلبي الاحتياجات الأساسية مما أدى إلى تحسن ملموس في صحة المواطن، حيث ارتفع معدل توقع الحياة في الجمهورية العربية السورية من ٥٦ عاماً عام ١٩٧٠، إلى ما يتجاوز ٧١ عاماً سنة ٢٠٠٤.

السيد الرئيس، إن ما يحدث اليوم من مآس في أنحاء العالم يصيب أعماق شعورنا بالحزن فهي ضد مبادئنا وقناعاتنا وممارساتنا، لذا فلشدّ ما يؤسفنا التعسف الذي يلحق بالشعب الفلسطيني من خلال الممارسات الهمجية الإسرائيلية، واجتياحها للأراضي والمدن والمخيمات الفلسطينية قاصدة تخريب المؤسسات التعليمية والصحية والاجتماعية.

وإننا نحمّل الحكومة الإسرائيلية المسؤولية كاملة عن المجازر والانتهاكات بحق الشعب الفلسطيني الأعزل، هذه الأعمال التي تؤكد رغبة الحكومة الإسرائيلية بالتنصل من عملية السلام العادل والشامل ضاربة عرض الحائط بقرارات مجلس الأمن والأمم المتحدة والشرعية الدولية. كما ندعو إلى صون صحة وكرامة المواطن العراقي ووحدة وسلامة أراضيه، وأعتقد أن فضيحة سجن أبو غريب ماثلة في ضمير العالم، ومن المؤسف أن تعاقب دول فقط لرفضها مبدئياً ما أدى إلى تلك المجازر والانتهاكات.

السيد الرئيس، لقد كنت سعيداً جداً بالأمس حين سمعت من تومي تومسن واليوم من الرئيس كارتر وجهاً إنسانياً للولايات المتحدة الأمريكية. في الختام، إن الجمهورية العربية السورية بقيادة السيد الرئيس بشار الأسد ستواصل مسعاها في مقاومة الإرهاب والمساهمة في إحلال سلام عادل وشامل مبني على قرارات الأمم المتحدة ووفق مرجعية مدريد ومبدأ الأرض مقابل السلام.

شكراً.

Mr GAO Qiang (China):

高强（中国）:

主席先生、各位部长、女士们、先生们:

近年来全球重大公共卫生事件不断涌现，SARS、禽流感、艾滋病等重大传染病对人类健康构成严重的威胁。中国代表团赞同李钟郁博士发表的重要讲话，支持世界卫生组织积极发挥协调和指导作用，共同抵御严重疾病的侵害。

经过去年抗击 SARS 的斗争，中国政府深刻地认识到公共卫生对保护人民健康、促进社会和经济发展的重要作用，提出了全面、协调、可持续的科学发展观，加强公共卫生体系建设，大幅度增加公共卫生投入，加强重大传染病的防治工作。目前一个统一、高效、准确、快速的疫情报告系统和应急指挥系统正在全国逐步形成，贯通城乡的公共卫生信息网络已经开始发挥作用。去冬今春，中国部分地区暴发了禽流感疫情。我们反应灵敏、行动迅速、措施果断、信息畅通，有效地控制了疫情，没有发生一例人间病例。今年四月下旬，北京和安徽出现了少数 SARS 病例，我们于当天就向社会民众、向世界卫生组织、向各国驻华使馆和港澳台地区通报了疫情，采取了一系列的控制措施。两天以内我们就基本确定了传染源。目前已经发现的 9 例 SARS 病例没有出现扩散，已有 6 人康复出院。回顾这些，我们不会忘记世界卫生组织和友好国家对我们的支持和帮助，我们表示深深的谢意。

主席先生、各位部长、女士们、先生们，

艾滋病是各国普遍面临的严重公共卫生问题和社会问题。中国的防治形势也很严峻。中国政府成立了国家级的防治艾滋病工作委员会，明确了各级政府的责任，广泛动员各方面的资源，加大资金投入，制定并实施了“四免一关怀”的政策，为农村居民和城市的经济困难的艾滋病患者免费提供抗病毒治疗药物，为自愿接受艾滋病检测咨询的人员免费提供咨询和血液检测，为感染艾滋病病毒的孕妇免费提供母婴阻断药物和儿童检测试剂，对艾滋病病人的孤儿免收上学费用。将生活困难的艾滋病病人纳入政府救助范围，加强健康宣传教育，反对社会歧视，强化行为干预措施，鼓励非政府组织、企业和个人参与艾滋病的防治工作，积极开展国际交流与合作。中国政府积极响应世界卫生组织和联合国艾滋病规划署提出的“三五”倡议，并期待开展更加有效的合作。

主席先生，

中国代表团曾多次指出，在卫生大会上搞涉台提案，将卫生问题政治化，势必严重干扰大会的正常工作。出现这种情况，是中国不愿看到的，也是绝大多数主持正义、真正关心卫生问题的国家所不愿看到的。借此机会，我想强调两点：第一，让台湾以“观察员”身份参加世界卫生组织，实质上是挑战中国的主权和领土完整，干涉中国内政。

对于这个问题，我们没有丝毫妥协的余地。第二，对台湾人民的健康福祉，我们历来并将继续高度重视和关心。我们欢迎台湾专家参加中国代表团出席世界卫生大会，愿意同 WHO 秘书处共同协商，在一个中国的原则下，研究并提出台湾专家参与 WHO 技术交流活动的有效办法。我们赞同绝大多数国家的意见，不愿意看到涉台问题再次干扰大会。

谢谢各位！

The PRESIDENT:

Thank you very much, the People's Republic of China. WHO appreciates the commendable work done to control SARS and avian influenza in the region.

Professor AKDAĞ (Turkey):

The new century opened with an unprecedented declaration of commitment to realize the Millennium Development Goals adopted at the Millennium Summit of the United Nations. We have reaffirmed our pledge to place particular focus on, and give priority attention to, the fight against the worldwide conditions that pose severe threats to the sustainable development of our people. These include, inter alia, communicable and chronic diseases, in particular HIV/AIDS, malaria and tuberculosis.

Combating HIV/AIDS, which constitutes a global emergency and a big challenge to human life and dignity as well as to human rights, has acquired a special urgency. The disease undermines social and economic development throughout the world. HIV/AIDS continues to affect people in all segments of society, especially targeting youth. The concerted efforts of the international community to develop effective and affordable vaccines or medicines for this epidemic must continue, to enable those suffering to live productive lives. We must also strengthen our prevention efforts. Treatment is an essential component of a comprehensive response to the HIV/AIDS epidemic. However, effective prevention programmes should accompany the treatment initiatives. Preventive measures are most effective in countries with a relatively low level of HIV prevalence. International solidarity is required in order to support countries suffering tremendously from the epidemic.

Health services should be strengthened to deal with all aspects of emergencies such as HIV/AIDS. To reach these targets, promotion of strong and accountable leadership at the level of governments, and encouragement of strong leadership by civil society, is needed. The private sector, as a demonstration of its social responsibility, must play an important role. Combating stigma and discrimination, and strengthening coordination, cooperation and partnership among Member States and international organizations are essential. We would like to commend, in this regard, the new leadership of WHO under Dr Lee Jong-wook for the very appropriate and timely initiative of "3 by 5", which we believe will have a positive impact on combating the epidemic.

Overall low HIV prevalence is thought to be the result of the traditional lifestyle to which most Turkish citizens adhere. However, we are aware that our country is not necessarily immune from the rapidly-increasing global influence of this epidemic. Our main target should be to control, eliminate or eradicate basic communicable diseases, including HIV/AIDS, by employing programmes to improve public health. As a result of the Global Polio Eradication Initiative, the vision of a polio-free world is now within reach. Turkey has also committed itself to eliminate measles by 2010. Programme activities on the elimination of the disease have already started throughout the country. The Millennium Development Goals provide the new international framework for measuring progress towards sustaining development and eliminating poverty. Turkey has been strengthening national strategies for making health services accessible to the people in greatest need, such as adolescents and the poor.

Last year, the Health Assembly adopted the WHO Framework Convention on Tobacco Control. As it is the first public health treaty negotiated by WHO, it constitutes a milestone in the protection of public health. Another global public health problem affecting all societies is road traffic injuries. A multisectoral approach which includes all stakeholders and is based on effective analysis, is a necessity to prevent this scourge which has one of the highest mortality and disability rates. We welcome the coordinating role of WHO for further action.

The PRESIDENT:

I now give the floor to the delegate of Guatemala who will speak on behalf of the Central American Group: Belize, Costa Rica, El Salvador, Honduras, Nicaragua, Panama, and on behalf of the Dominican Republic and of his own country.

El Dr. SOSA RAMÍREZ (Guatemala):

Señor Presidente: permítame felicitarlo por su elección y augurarle muchos éxitos a lo largo de esta Asamblea. Señores Ministros, señores delegados, damas y caballeros: en mi calidad de Presidente *pro tempore* del Consejo de Ministros de Salud de Centroamérica tengo el honor de dirigirme a esta honorable Asamblea Mundial de la Salud en representación de la subregión centroamericana y de la República Dominicana con la encomienda de ser el portador del saludo cordial de los Ministros de Salud, así como de hacer partícipe a los miembros de esta Asamblea sobre los avances que como países integrados hemos alcanzado en materia de salud pública.

Como fruto del trabajo conjunto cabe subrayar en primer lugar los esfuerzos realizados para contrarrestar la epidemia de SRAS que el año pasado amenazó a Centroamérica, y en el que la unión de los países permitió establecer una vigilancia efectiva en todos los lugares de acceso a la subregión para la detección temprana de algún brote y la aplicación de medidas de prevención oportunas.

La amenaza potencial del SRAS y la posibilidad de otras epidemias igualmente peligrosas, como la fiebre del Nilo occidental, la encefalitis equina y la enfermedad de las vacas locas, nos permitió establecer pautas colectivas de prevención y control, que además fortalecen la Red Centroamericana para el Control de Enfermedades Emergentes y Reemergentes, constituidas por los equipos técnicos del Ministerio de Salud en el afán de abordar los nuevos riesgos de la salud pública.

En el mismo sentido de aunar esfuerzos para la vigilancia y control de enfermedades, la subregión ha extendido su accionar de coordinación con otros bloques regionales, aprovechando los espacios generados por las cumbres de presidentes, especialmente en el marco del Plan Puebla Panamá. A este respecto, en septiembre del año pasado se suscribió con la Secretaría de Salud de México un Memorándum de Entendimiento del Componente de Salud de la Iniciativa Mesoamericana de Desarrollo Humano, del Plan Puebla Panamá. Esta experiencia ha permitido a su vez la negociación de un acuerdo similar con el Consejo de Ministros de la subregión del Caribe.

Los Ministros de Salud de Centroamérica también hemos sido promotores de esfuerzos que contribuyen al mejoramiento de las condiciones de vida de las poblaciones más desposeídas de nuestros países, por lo que en coordinación con nuestros homólogos, el Consejo de Ministros de Integración Social y el Consejo de Ministros Agropecuarios, hemos logrado impulsar, dentro de la agenda de los Jefes de Gobierno y de Estado de Centroamérica, la Iniciativa de Seguridad Alimentaria y Nutricional, la cual incluye un marco estratégico para enfrentar la inseguridad alimentaria y nutricional. En seguimiento a este mandato, los Consejos de Ministros de Salud, Agricultura y de Ambiente estaremos reuniéndonos en Guatemala los días 24 y 25 de junio próximos.

Otro logro importante de la subregión ha sido el apoyo de la cooperación japonesa, que agradecemos, para la formulación del Proyecto de Mejoramiento de la Calidad de los Servicios de Salud, basado en la evidencia y la participación, y el cual ha generado el desarrollo de un programa quinquenal de entrenamiento a capacitadores de la subregión, así como para el desarrollo del programa regional de prevención y control de la enfermedad de Chagas en El Salvador, Honduras, Nicaragua y Guatemala.

En cuanto a la concertación de entidades de salud de las zonas fronterizas, ha sido un proceso permanente que ha dado como resultado la sistematización de acciones de promoción, prevención,

reducción y control de la vulnerabilidad en municipios fronterizos establecidos como prioritarios y desarrolladas en el marco de prioridades nacionales.

Especial mención merecen el impulso de las acciones de salud en las zonas fronterizas del Proyecto Mesoamericano de Atención Integral a la Población Migrante, reduciendo la vulnerabilidad de la población migrante en Centroamérica frente al VIH/SIDA.

Es importante también mencionar el valioso soporte del Organismo Sueco de Desarrollo Internacional, y del Instituto Nacional para la Vida Laboral, quienes en coordinación con el Instituto Centroamericano de Estudios en Sustancias Tóxicas de la Universidad Nacional de Costa Rica, y la Universidad Autónoma de Nicaragua en León, han iniciado en Centroamérica la implementación de la primera fase del Programa Trabajo y Salud en Centroamérica, cuya duración está estimada en cuatro años. Este programa será de mucho beneficio, dado que incluye proyectos de gran trascendencia para el sector laboral. Entre éstos destacan la acción para la promoción de la salud y la reducción de riesgos en la industria de la construcción y en la producción del azúcar de caña, la promoción de la salud laboral y la prevención de riesgos para el personal de hospitales, hoteles y restaurantes, la identificación de amenazas y estudios de brotes, el establecimiento de redes regionales interdisciplinarias de profesionales en seguridad y salud ocupacional, el fortalecimiento de los programas de entrenamiento preexistentes y el establecimiento de una infraestructura organizacional de la región y de un sistema de comunicación de la información sobre seguridad y salud ocupacional.

Para concluir me permito reiterar el compromiso del Consejo de Ministros de Salud de Centroamérica, de seguir impulsando iniciativas conjuntas dirigidas a mejorar la salud y la nutrición en nuestros pueblos, así como de continuar buscando el entendimiento con otros bloques regionales que permitan establecer una cooperación horizontal tanto en el área de vigilancia y control epidemiológico como en otros rubros importantes que coadyuven a avanzar con paso firme en la consecución de los Objetivos de Desarrollo del Milenio.

El Dr. BONILLA (Uruguay):

Señor Presidente, señor Director General, señores Ministros, señores delegados, señoras y señores: dados estos breves minutos en los cuales podemos expresar nuestra opinión, queremos concentrar nuestra alocución en el tema del VIH/SIDA en la República Oriental del Uruguay. La epidemia en nuestro país es una epidemia absolutamente concentrada: hay baja prevalencia de infección por VIH en la población general, 0,36%, y 0,20% en las embarazadas. En cambio hay una alta prevalencia en los grupos vulnerables, trabajadores sexuales masculinos (21%), reclusos (6%), y usuarios de drogas inhalantes (9,5%). La tasa de incidencia anual del VIH es de 169 casos por cada 100 000 habitantes, y en los casos de SIDA es de 77 casos cada 100 000 habitantes; un 76% corresponde a hombres, y un 24% a mujeres.

¿Cómo ha crecido esta epidemia? Los estudios muestran, comparando las prevalencias de los estudios centinela del año 2000 con respecto a los del 2003, que partíamos de un 0,23% y ahora estamos en un 0,36%, casi una duplicación a pesar de ser números bajos, de la prevalencia en la población laboral, con un aumento en la participación de la mujer y una franca disminución de la edad de las personas afectadas: sobre todo son de 15 a 24 años.

La epidemia de SIDA en el Uruguay se caracterizó y se caracteriza por el predominio de la transmisión sexual. El 70% de los casos es por esta vía de transmisión. La segunda vía es la sanguínea, casi exclusiva de los usuarios de drogas intravenosas, y representa el 28% de los casos notificados, con una tendencia creciente en aumento. Y la tercera vía de transmisión es la vertical, que hoy es nada más, por suerte, que el 2% de los casos de VIH/SIDA notificados, y es una vía que en el año 1995 era el 50% y ahora hemos logrado bajar el 4%.

¿Qué logros se han conseguido y cuáles son los problemas? En primer lugar, en cuanto a los logros, el tamizaje obligatorio de toda la sangre y hemoderivados en todo el territorio nacional se ha logrado desde el año 1988. Se da cobertura del 100% de terapia antirretroviral pública y privada a todos los enfermos de SIDA en el país. Ha disminuido la letalidad por SIDA en un 30% a partir del año 1997, y ha disminuido la transmisión vertical del VIH de madre a hijo, que era del orden de casi el 50% en el año 1996, a 4% en el año 2004.

El Uruguay presenta entonces una epidemia concentrada en poblaciones vulnerables, por lo cual lo que debemos hacer es implementar estrategias específicas para esa población y disminuir el riesgo de generalización de la epidemia en los próximos 10 años. Debemos intensificar la prevención mediante acciones que ya estamos instrumentando en esos grupos vulnerables. El Uruguay ha tenido una crisis económica muy grave y muy seria durante los años 2002 y 2003, pero a pesar de esa crisis económica que le tocó enfrentar, en ningún momento el Uruguay interrumpió la terapia antirretroviral al 100%. Pero se nos hace cuesta arriba continuarla, no podemos continuarla. El acceso a la medicación en el Uruguay es universal, con 100% de cobertura, y necesitamos entonces insistir y reanudar contacto a nivel de las autoridades del Fondo Mundial de Lucha contra el SIDA, la Tuberculosis y la Malaria, para que consideren las propuestas enviadas por el Uruguay y que en su momento fueron rechazadas. El apoyo financiero y técnico del Fondo Mundial es vital para nuestro país. Nos permitiría implementar los programas de prevención que queremos mantener para tener esos buenos números que hemos conseguido en la población general y dar continuidad a los tratamientos antirretrovirales que actualmente se proporcionan a todas las personas enfermas de SIDA.

The PRESIDENT:

Thank you, the honourable delegate of Uruguay. The Health Assembly is appreciative of your focus on HIV/AIDS control.

Mr KARKI (Nepal):

I would like to express our sincere appreciation to Dr Lee Jong-wook, the Director-General of WHO, for his inspiring statement yesterday, in which he so eloquently touched upon many important issues such as HIV/AIDS, conflict and health, poverty and health, Millennium Development Goals, and capacity building. Similarly, the account of Anastasia was very moving. They have set the tone for our deliberations.

This year's Health Assembly has important and urgent agenda items before it. The fight against HIV/AIDS, together with tuberculosis and malaria; the draft global strategy on diet, physical activity and health; road safety; and reproductive health are, among others, key priority issues. Although they are global issues of concern, many of these problems are severe in the developing countries and in the least developed countries, in particular. We can deal with them only by effectively promoting complementarities between national efforts and international cooperation, by sustaining our programmes through strengthening the capacities of national health systems, and by encompassing all the stakeholders in an inclusive approach.

We are happy that the focus of *The world health report 2004* is on HIV/AIDS. In this context, it is only appropriate that the debate and the interactions at the ministerial round tables of this year's Health Assembly have focused exclusively on HIV/AIDS, which is undoubtedly the most compelling public health crisis of our time. To deal with the global challenge there is a need, in our view, for the formulation of comprehensive strategies, enhancement of resources, and sustained and focused programmes on all aspects of HIV/AIDS. Comprehensive mapping should be our continued priority to understand the full scale and scope of its spread. It is only by doing so that we can fully contain and tackle the menace, including the possibility of co-infection with other deadly diseases such as tuberculosis.

His Majesty's Government of Nepal is committed to upgrading the overall health of its people. We have made good progress on poliomyelitis eradication. We are looking forward to polio-free certification. Maternal and neonatal tetanus elimination and measles elimination campaigns are also on the path to progress. Hopefully, the leprosy elimination target will be achieved by the year 2005. Nepal's national tuberculosis control programme has reached to 90% of the population through directly observed treatment, short course (DOTS) and the coverage will increase in the coming years. But still we are far from achieving the goals that we have set for ourselves. We are experiencing high maternal and neonatal mortality rates in the country. Therefore His Majesty's Government of Nepal has adopted several interventions, from the grassroots to institutional levels.

Emergence and re-emergence of communicable diseases like kala-azar, malaria and tuberculosis, together with noncommunicable diseases, are the new problems with which we are currently beset. Improving the health of women during pregnancy and lactation, saving the lives of neonates, and having control over both communicable and noncommunicable diseases are other huge challenges before us. In order to deal with these and other important public health issues, and also to accelerate and scale up these activities, His Majesty's Government of Nepal has recently approved the Nepal health reform strategy, which is our comprehensive agenda for reform. The strategy has been prepared through wide public/private participation, including consultations with media representatives and development partners. The next important initiative is the decentralization of the health services. We have already handed over the management of approximately 1200 community health institutions to local bodies, and we look forward to making more such handovers in the near future. Meanwhile, nongovernmental and private health sectors are emerging confidently in the country. Commensurate with these developments, the Ministry of Health is trying to redefine its role and responsibilities.

Nepal is not immune to worldly, deadly diseases like HIV/AIDS. Although the reported number of HIV/AIDS-infected people in Nepal is only about 3500, the disease is severe in the country, where it is projected to affect 60 000 persons. We have started to distribute antiretroviral drugs free of charge, on a smaller scale, to patients suffering from HIV/AIDS. Additionally, and in order to control HIV/AIDS in an effective manner, a new strategy has been developed and several ministries, along with nongovernmental organizations, have been identified as partners for this purpose. However, we have been experiencing continued constraints in distributing the antiretroviral drugs to all HIV/AIDS patients. It is beyond our capacity to do away with this limitation. Therefore, I would like to call upon the concerned agencies, including WHO, to act decisively towards reducing the price, monitoring the quality of the drugs, and providing such assistance to us in the near future. I am sure that it will be a positive step towards achieving the target set in the Millennium Development Goals.

I would like to take this opportunity to express our sincere appreciation to all our development partners, and especially to the World Health Organization, for their consistent support and cooperation over the years in our efforts to deal with public health issues, and for building capacity and institutions in the country. We sincerely hope that in our national efforts for health sector reform, we will also continue to receive support and cooperation from WHO and the international community.

The PRESIDENT:

Thank you, the honourable delegate of Nepal, for focusing on the continued mapping of HIV/AIDS and its deadly effect when it mingles with other diseases, and also on the reduction in price of antiretroviral drugs.

Mr ABDULLAH (Maldives):

Bismillah arrahman arrahim.

We are very heartened by the innovative leadership of the Director-General, Dr Lee, who has infused into WHO strong leadership to make a difference. His "3 by 5" initiative deserves commendation. I am confident that "3 by 5" will make history by turning the nightmare of HIV/AIDS into a promising reality of hope. However, I am sure that prevention will remain the underlying principle. With WHO, we are also rededicating our efforts to the health of mothers and children. It is timely that we have just celebrated the tenth anniversary of the International Year of the Family. The deteriorating global nutrition situation is a major cause for concern. Malnutrition continues to affect millions. Over-nutrition and obesity are equally worrisome. Errant advertising and marketing of unhealthy food is a huge obstacle to be addressed. The international community and governments share a moral responsibility to protect people. WHO's draft global strategy on diet, physical activity and health is a timely step to combat the looming epidemic of noncommunicable diseases and many other challenges. We applaud this draft strategy and the WHO Framework Convention on Tobacco Control as landmark steps, and I am happy to inform that Maldives has signed and ratified the Framework Convention. With our main thrust on prevention, we are also vigorously promoting healthy behaviours as a key to good health.

We are all committed to strengthening our health systems and WHO must do more in this crucial task. The Health Leadership Service initiative to groom a new leadership in public health is laudable. Able leadership is essential to strengthen health systems and make a difference. President Maumoon Abdul Gayoom's deep commitment has enabled Maldives to invest about 11% of the national budget in health. It has brought promising results. In this uphill task, Maldives has benefited from its partnership with WHO and the international community. Life expectancy has increased to over 72 years, infant mortality has decreased to 17 per 1000 live births, and the maternal mortality rate has declined to 120. Promotive and preventive measures are our most effective tools for sustainable health. In this Herculean task, we must strengthen school health and make students a powerful partner. We are relentlessly exploring new frontiers to provide affordable and effective medicines. In this critical area, the role of traditional and alternative medicine is very important. There is an urgent need for WHO to dedicate more to this issue and to strengthen the regulatory mechanisms.

I would like to pay tribute to the former Director-General, Dr Brundtland, for her brilliant leadership. Former Regional Director, Dr Uton Muchtar Rafei, also deserves our praise. We have great confidence in Dr Lee to lead us to new frontiers of success. I extend to him sincere congratulations and best wishes. I also warmly congratulate Dr Samlee Plianbangchang, our new Regional Director, and wish him every success. I wish this Health Assembly every success. *Assalamu alaikum.*

The PRESIDENT:

Thank you, honourable delegate of Maldives. WHO appreciates that Maldives has signed the Framework Convention and urges other nations to follow.

Professor HOMIEDA (Sudan):

الدكتور حوميدة مأمون (السودان):

بسم الله الرحمن الرحيم،

سعادة السيد الرئيس، سعادة السيد المدير العام لمنظمة الصحة العالمية، أصحاب الفخامة السادة الوزراء، السادة والسيدات الحضور، السلام عليكم ورحمة الله تعالى وبركاته.

في فاتحة هذه الكلمة نهنئ السيد الرئيس باختياره لهذا المنصب كما نهنئ المدير العام للمنظمة الدكتور لي لخطابه الضافي واللفتة البارعة بإشراك ميس أنستازيا والتي حركت مشاعر هذا الاجتماع.

سادتي الحضور الكريم، يأتي انعقاد جمعية الصحة العالمية السابعة والخمسين في ظروف بالغة التعقيد فيما يخص الوضع الصحي العالمي. فالأمراض السارية كمتلازمة العوز المناعي (الأيدز) والملاريا والسل لاتزال تنتشر بمعدلات عالية في الكثير من البلاد - خصوصاً في الدول النامية - مخلفة أعداداً كثيرة من المرضى والوفيات مما يؤثر على الأداء الاقتصادي لهذه الدول. كما أن استمرار المعدلات المتسارعة للتدهور البيئي والاستعمال غير الرشيد للموارد الطبيعية يسهم بصورة متزايدة في خلق بيئة غير صحية مما يمثل خطراً على الأمن العالمي، كذلك يسهم السلوك غير الصحي من مجموعات مختلفة في زيادات معدلات الاختطار والانتشار للعديد من الأمراض والمشاكل التي تؤثر على صحة المواطنين. فحوادث الطرق وحدها تحدث سنوياً أعداداً كبيرة من الموتى والمعاقين والحروب التي تنتشر في أنحاء المعمورة لاتزال تشكل عبئاً ثقيلاً على الصحة.

سادتي الحضور الكريم، يطيب لي أن نعرض تلخيصاً سريعاً لما قامت به حكومة السودان ووزارة الصحة من أعمال كبيرة وما حققته من انجازات في مهمة إحداث الصحة في الفترة السابقة. ولعل من أهم تلك الإنجازات النقلة النوعية في مكافحة الملاريا وذلك بتغيير بروتوكول علاج الملاريا الذي لم يكن فعالاً وتنفيذ مشروع خفض الوفيات وغيرها من الإجراءات ومعينات العمل الشيء الذي نتوقع أن ينعكس إيجاباً ويحدث نقلة في حربنا على مرض الملاريا. كذلك احتفلت الوزارة في عام ٢٠٠٣ بإعلان التغطية الشاملة لجميع القطر بمراكز تشخيص ومعالجة السل حسب المستهدف العالمي مع توفير الدواء ومواد الفحص مجاناً. أما في إطار الحرب على الأيدز فإن الوزارة قامت بمراجعة سياسة البرنامج القومي للأيدز. كما تم توفير مواد فحص الدم للأيدز وتوزيعها على جميع المستشفيات. وأيضاً تمت موجهات السلامة داخل بنوك الدم. وقد كان ذلك مصحوباً بحملة توعية شاملة لتسليح جميع المواطنين بثقافة ووعي بالمرض وأساليب التعامل معه ومكافحته.

وفي مجال استئصال الفرنديد (الدودة الغينية) تم اكتشاف ١٥٨٣ حالة جديدة واتخذت الوزارة الإجراءات الكفيلة باحتوائها، ولعلنا استطعنا في أن ننجح في جعل المرض تحت السيطرة في كل المناطق الآمنة ولانزال في انتظار أن يحل السلام بالبلاد خاصة في جنوبه للقضاء النهائي على المرض في دولة لاتزال الأكثر احتواءً على المرض.

لعل الرعاية الصحية الأولية تعد من الأولويات المتقدمة للوزارة، ففي عام ٢٠٠٣ أدخلت مبادرات مجتمعية جديدة مثل نظام المدن الصحية والمدرسة المجتمعية وتعزيز دور المرأة في الصحة والتنمية. كما تم إعداد دليل لمنظمات المعلومات والشبكة الحيوية للمنطقة الصحية. وفي مجال التحصين تفخر الوزارة بإعلان تحقيق هدف خلو البلاد من فيروس الشلل البري لفترة تزيد على ثلاث سنوات. أما في مجال صحة الطفل فقد أنجزت الوزارة توسعاً في مجال التغطية بالعلاج المتكامل لأمراض الطفولة.

سادتي الحضور الكريم، إن وزارة الصحة إذ تعرض عليكم عملها للعام ٢٠٠٣ فهي تدرك أنها مواجهة في عام ٢٠٠٤ بتحديات على مستوى جديد هي:

- زيادة حركة السكان في مناطق الحرب مما يساعد على انتشار المرض.
- زيادة حركة السكان عبر الحدود مع الدول المجاورة الشيء الذي يساعد على انتقال المرض من هذه البلاد وبخاصة مرض الأيدز.
- السلام والذي نتوقع أن يحدث في أي وقت يجعل الوصول إلى بعض المناطق المتأثرة بالحرب أمراً ممكناً ولم يكن ذلك كذلك في أثناء الحرب. الشيء الذي يطرح تحدياً لتغطية هذه المناطق بالخدمات الصحية الأساسية واضعين في الحسبان غياب البنية التحتية الصحية تماماً في تلك المناطق التي كانت تصاب بالحرب.

ولابد، ونحن نسرد التحديات الصحية التي يطرحها السلام، أن ننوه بالدور الفاعل والتنسيق التام الذي يتم بين وزارة الصحة ومنظمة الصحة العالمية ممثلة في مقرها الرئيسي في جنيف ومكتبها الإقليمي في القاهرة ومكتبها القطري في الخرطوم في إعداد ووضع وثيقة إعمار النظام الصحي لفترة ما بعد الحرب. ووزارة الصحة، إذ تثمّن الدور الذي تلعبه منظمة الصحة العالمية، فهي تأمل وتنتظر تمويلاً يتناسب والبرنامج الضخم الذي تعده الوزارة لمواجهة التحديات الصحية لفترة ما بعد الحرب. ونحن في وزارة الصحة نناشد منظمة الصحة العالمية وجميع المنظمات والهيئات المانحة الأخرى دعم برامج الوزارة مما يحقق شراكة حقيقية بيننا وبين تلك المنظمات والهيئات في رفع المستوى الصحي في السودان.

سادتي الحضور، لا يمكن الحديث في هموم الصحة دون الإشارة للأوضاع الصحية الصعبة التي يعانيها الشعب الفلسطيني جراء الاحتلال وعمليات الهدم والتشريد والعزل ولعل ما يحدث الآن في قطاع غزة في فلسطين يقف خير شاهد على ذلك ولابد أن نناشد كل الحكومات والمنظمات والهيئات المهتمة بشأن الصحة الالتفات إلى تلك الأوضاع الصحية الخطيرة بالجدية اللازمة التي تضمن الحقوق الأساسية للمواطنين في فلسطين.

والسلام عليكم ورحمة الله.

The PRESIDENT:

Thank you very much, the honourable delegate of Sudan. We compliment you on your work on the screening of blood before transfusion: that is critical. We also appreciate your efforts for peace in the area. For any health policy to succeed, it is important that we have peace.

Le Dr BIJOU (Haïti) :

Monsieur le Président, Mesdames et Messieurs les Ministres, honorables délégués, Mesdames et Messieurs, tout d'abord, au nom de mon Gouvernement, je tiens à renouveler toutes mes félicitations au Président de notre Cinquante-Septième Assemblée mondiale de la Santé pour son élection ; mes félicitations s'adressent également aux membres du Bureau. Je saisis aussi cette occasion pour

présenter mes compliments au Directeur général de l'OMS pour sa bonne gestion de l'Organisation et du travail qu'il réalise.

L'honneur qui m'échet de représenter le Gouvernement haïtien à cette Assemblée me comble d'une joie teintée d'émotion : plaisir de rejoindre les ministres de la santé et d'autres personnalités des Etats Membres réunis dans cette enceinte pour méditer sur les problèmes médico-sanitaires qui affectent les peuples, et serrement de coeur à la remémoration des récentes commotions sociopolitiques qui ont secoué mon pays. Cette crise n'a pas été sans effet sur le secteur santé. En effet, la situation était déjà précaire avec des indicateurs évoluant vers la hausse, soit une mortalité maternelle qui est passée de 457 pour 100 000 naissances vivantes en 1995 à 523 en 2000 et une mortalité infantile qui est passée de 74 pour 1000 naissances vivantes en 1995 à 80 en l'an 2000. Aujourd'hui, alors que le progrès humain semble atteindre son point culminant dans la plupart des régions de la planète, le maintien des relations pacifiques semble devenir une utopie dans mon pays. Depuis plus d'une décennie, la violence érigée en système a jeté le désarroi dans les familles, créant des situations cahotiques propres à augmenter la misère et les souffrances des populations, en particulier les plus vulnérables : les femmes, les jeunes et les enfants. A l'occasion de ces derniers événements, la situation s'est aggravée, l'insécurité qui sévissait dans la plupart des grands hôpitaux du pays avait conduit à la désertion du personnel, d'où une réduction systématique de l'offre de services et la discontinuité même du service d'urgence dans les centres publics. Les centres privés, tant bien que mal, essayaient de suppléer, mais avec une capacité vraiment insuffisante. D'un autre côté, c'était l'arrêt complet de certains programmes prioritaires, comme la vaccination, avec les risques de réémergence de certaines maladies éradiquées ou en voie d'éradication comme la poliomyélite, la rougeole et le tétanos. L'approvisionnement des institutions sanitaires a été perturbé. On n'a pas rapporté de cas de pillage lors du transport des médicaments ou du matériel médical, mais le manque de carburant et de véhicules a cependant rendu difficiles ces opérations, car la flotte de véhicules du secteur de la santé, qu'il s'agisse du public ou du privé, et même de la Croix-Rouge, n'a pas été épargnée. Un nombre important de véhicules du Ministère de la Santé a été volé dans l'enceinte même des bâtiments sanitaires. Les programmes de lutte contre le VIH/SIDA, la tuberculose et le paludisme ont beaucoup souffert en raison de la non-disponibilité de médicaments et d'intrants dans les centres de diagnostic et de traitement.

Mesdames et Messieurs, Haïti est l'un des pays les plus touchés par la pandémie de VIH/SIDA. Les premiers cas remontent aux années 80. On ne saurait oublier si vite qu'au début, être Haïtien était considéré comme un facteur de risque de SIDA. Heureusement, les progrès de la science ont vite prouvé le contraire. Cette situation qui avait créé la panique dans mon pays a cependant servi. Dès le début, la lutte contre le VIH/SIDA a bénéficié de l'appui politique des plus hautes autorités du pays. Une commission nationale fut créée. Plus tard, un plan stratégique fut élaboré autour des axes suivants : le renforcement de l'éducation et de la sensibilisation de la population afin de diminuer la stigmatisation et la discrimination ; une approche multisectorielle impliquant les jeunes, le secteur religieux, les ONG, les partenaires internationaux, les personnes vivant avec le VIH ; la lutte contre la transmission mère-enfant ; la sécurité transfusionnelle et les infections nosocomiales ; le traitement des infections opportunistes ; la prophylaxie dans les cas de violence sexuelle ; les traitements antirétroviraux ; l'installation de sites de dépistage volontaire et d'assistance-conseil. Des essais vaccinaux sont également en cours depuis environ deux ans. Toutes ces actions ont conduit à une diminution spectaculaire de la prévalence de la maladie qui est passée de 4,6 à 2,9 en l'espace de trois années. Ces résultats ont été prouvés à partir de l'enquête de séroprévalence réalisée chez les femmes enceintes au niveau du pays.

En tant que pays très affecté, nous félicitons le Directeur général de l'OMS pour le lancement de l'initiative « 3 millions d'ici 2005 ». Cependant, nous sommes très préoccupés par les faits suivants : actuellement, seulement deux institutions privées fournissent un traitement à 20 % de la population, soit moins de 2000 patients sur un total de 17 000 prévus ; d'autre part, les structures étatiques de santé sont faibles, et les revenus de l'Etat sont trop bas pour pouvoir prendre en charge les frais du traitement et l'étendre à un plus fort pourcentage de personnes vivant avec le VIH, le coût du traitement demeurant bien au-dessus de la bourse de l'Haïtien moyen. D'autres avant moi l'ont dit, mais j'insiste sur le fait que le renforcement du système de santé publique est une condition indispensable au succès de l'initiative « 3 millions d'ici 2005 ».

Pour terminer, nous voulons mentionner les efforts de coordination entrepris par le Ministère de la Santé et les discussions en cours avec les différents partenaires afin de garantir une distribution plus équitable des soins aux personnes vivant avec le VIH. Pour cela, un appui technique soutenu de l'OMS dans la Région des Amériques se révèle plus que nécessaire. Je vous remercie.

The PRESIDENT:

Thank you, Haiti. Your concern is that yours is a country severely affected by HIV/AIDS and by the high cost of treatment.

PEHIN DATO ABU BAKAR APONG (Brunei Darussalam):

Bismillah arrahman arrahim.

Since its first detection in the early 1980s, HIV/AIDS has become one of the major public health problems facing the modern world and has spread to epidemic proportions. It is a tragedy to note that as of December 2003, a cumulative total of 40 million people were living with HIV/AIDS, with five million people newly infected and three million deaths in 2003 alone. We should not see these figures as statistics but as a wake up call to what this epidemic is capable of, and its immediate and long-term consequences. Since the resolution on scaling up the response to HIV/AIDS adopted in May 2001 during the Fifty-fourth World Health Assembly and the signing of the Declaration of Commitment on HIV/AIDS in June 2001 during the Twenty-sixth special session of the United Nations General Assembly, the world's nations have pledged their commitment, resources and actions to defeating HIV/AIDS. However, it is sad to note that several of the Declaration's targets for the year 2003 were never reached. Significant barriers still exist to the use of health services by people with HIV/AIDS, in particular stigmatization and discrimination, accessibility of treatment and disjointed prevention, treatment and care programmes.

Alhamdulillah, HIV/AIDS prevalence in Brunei Darussalam continues to be at a low level, with new cases predominantly detected among foreign workers. Since the availability of HIV screening in August 1986 and up to December 2003, a cumulative total of 25 cases amongst locals has been detected. Sexual contact continues to be the predominant mode of transmission with the majority of cases being males (64%) and in the age group 20-39 years (56%). However, despite the low prevalence rates, Brunei Darussalam remains committed to the prevention, treatment and control of HIV/AIDS. A National Committee on Communicable Disease with special reference to HIV/AIDS was formed in 1988. Prevention and control strategies adopted include ensuring the safe supply of blood and blood products, intensifying surveillance of high-risk groups, strengthening the HIV/AIDS awareness and education programme involving both government and nongovernment sectors, and case management including clinical care, support and counselling. Apart from the efforts undertaken by the Ministry of Health, the Brunei Darussalam AIDS Council (a nongovernmental agency) has been actively collaborating in awareness and educational programmes targeting youth, women and the general public. In Brunei Darussalam, we are aware of the challenges of HIV/AIDS prevention, treatment and care programmes and are addressing the factors contributing to HIV/AIDS vulnerability, such as behaviours and lifestyle, social structure and values, population mobility, and drug use, as well as economic and employment status. On the positive side, various opportunities for effective intervention exist in Brunei Darussalam, including the low level of infection, a small and accessible population, the existence of related on-going programmes such as healthy lifestyle, recognition at the highest level that a multisectoral approach is essential in HIV/AIDS management, allocation of available resources to several government agencies, regional best practices for reference, and availability of technical support from regional and international bodies. In this regard, I would like to commend and express my heartfelt appreciation to the WHO Regional Office for the Western Pacific, as well as various agencies such as ASEAN, for providing support to Brunei Darussalam's efforts in combating this epidemic.

The recent outbreaks of severe acute respiratory syndrome and avian influenza have certainly driven home the message that we need to be constantly vigilant. In fact, during the 7th ASEAN Health Ministers Meeting held last April, the chosen theme was "Health Without Frontiers". This signifies the

realization that recent events represent the borderless nature of the global village and community. The spread of severe acute respiratory syndrome and the avian influenza epidemics in several countries in the region sent and reinforced the message of the need for intelligent partnership, not only among the ASEAN member countries but all countries of the world. Indeed, the historical perspective where diseases and epidemics spread across borders has provided us with the conventional wisdom that there is strength in numbers. The issues of the borderless world of health, economics and sociopolitical matters are real. They have posed challenges to us all in many different forms and dimensions. We in the health sector have realized that health is not isolated and does not stand on its own. The cross-cutting nature of the issues requires us to work in tandem with all our partners, not only in health but also in many other areas. Brunei Darussalam has taken several positive steps with regard to these issues, such as the enactment of the Infectious Diseases Order and its incorporation in the domestic laws of Brunei Darussalam and the establishment of the National Task Force on Severe Acute Respiratory Syndrome and the National Task Force on Zoonotic Diseases. This clearly reflects the concern and commitment of His Majesty's Government on these issues. Cooperation and collaboration are vital and Brunei Darussalam supports the exchange of information and knowledge of emerging and resurging infections that can threaten the region and the world. In this regard, Brunei Darussalam is willing to share its experiences in containing malaria and dengue and welcomes member countries who wish to send their officers on short missions.

My statement will not be complete if I do not mention the efforts being made by Brunei Darussalam to minimize death through traffic accidents. In this regard, I must congratulate WHO for choosing "Road Safety Is No Accident" as the theme of this year's World Health Day. According to WHO statistics, road traffic accidents result in 1.2 million deaths per year worldwide, with 20 to 50 million more seriously injured, causing untold suffering. These figures are very alarming indeed. Left unchecked, the number will certainly increase. Therefore, injury through traffic accidents is a public health problem that needs serious attention. In Brunei Darussalam, vehicles are widely used and the number of road traffic accidents is also on the increase. Death from road traffic accidents is the sixth leading cause of death in Brunei Darussalam. In this regard, Brunei Darussalam is stepping up its efforts to minimize that number by involving various governmental and public sectors such as health, transportation, education, development and, of course, law enforcement. Apart from the Government's commitment to monitor and evaluate road safety policy and programmes, efforts to involve the public are also continuously being stepped up.

The PRESIDENT:

Thank you very much, honourable delegate of Brunei Darussalam. You are focusing on scaling up the response to the HIV/AIDS virus. Targets set must be met and exchange of information between countries is imperative. You have done good work on road traffic accidents.

El Dr. CAPELLA MATEO (Venezuela):

Señor Presidente, honorables Ministros y Ministras, distinguidos señoras y señores acompañantes de las delegaciones: Venezuela ha asumido el problema del VIH/SIDA, así como las enfermedades de alto costo, como un problema de Estado. Tal como lo establece la Constitución Nacional de la República Bolivariana de Venezuela, el Gobierno financia el tratamiento a quienes viven con VIH/SIDA, y ejecuta proyectos y programas masivos de prevención, promoción de la salud y educación para evitar la enfermedad. Esto está a la vista y es conocido por todos. Lamentamos que la OMS y el ONUSIDA ignoren en sus publicaciones recientemente distribuidas que el Estado venezolano garantiza la total cobertura de las necesidades terapéuticas de las personas que en nuestro país viven con esta enfermedad a través de 17 medicamentos diferentes, y la distribución gratuita y universal que garantiza el acceso a las pruebas de diagnóstico presuntivo y confirmatorio, a los marcadores, al tratamiento de infecciones oportunistas, al soporte nutricional de lactantes afectados o hijos de madres con VIH/SIDA, entre otros. Este es un gigantesco esfuerzo que realiza el país.

Allá en Venezuela se garantiza la aplicación de sus políticas con el amplio programa de atención primaria que conocemos como «Barrio Adentro».

Venezuela apoya la política del «3 por 5» de manera irrestricta, pero quisiéramos llamar también la atención sobre la naturaleza de esta propuesta. Cualquiera pudiera imaginar que pudo ser elaborada por los fabricantes de los medicamentos y no por quienes planifican la construcción de espacios de salud en el mundo. Con la misma fuerza, debería promoverse una política dirigida a prevenir la enfermedad con las estrategias conocidas y todas aquellas que puedan proponerse para evitar la contaminación y la propagación de este fatal flagelo.

Más aún, estamos conscientes como lo están todos los países de este planeta, sobre la importancia del VIH/SIDA, capaz de convocarnos a una Conferencia Mundial para abordar este tema como principal. Pensamos que los mayores esfuerzos económicos deben dirigirse a la investigación de la búsqueda de la vacuna que prevenga la enfermedad. Ésta sería la verdadera respuesta. La humanidad entera agradecería a la OMS y a los gobiernos del mundo una iniciativa de esta magnitud.

La política del «3 por 5» precisa ser mejor caracterizada. Precisa además definir el grado de responsabilidad de los países del Norte poseedores de alta tecnología, dueños de las patentes, en el compromiso humanitario y solidario con los países de este planeta.
Nuestra nación se sentiría felizmente complacida, si la política del «3 por 5» no produjese un dólar de lucro a nadie a cambio de garantizarle la vida a tres millones de seres humanos. No estamos totalmente convencidos que detrás de esta propuesta no se construyan muros de inequidad, en un mundo ya perversamente excluyente.

Esperamos de la OMS la certeza de que la iniciativa responda a la ejecución real de la participación de la prioridad nacional por encima de otros intereses unilaterales. ¿Cuáles son los mecanismos que garantizarían el fortalecimiento nacional en un periodo tan breve? ¿Cómo se evidencia el refuerzo de las capacidades nacionales para el logro de estos objetivos? Dejamos estas preguntas a la Asamblea.

Para finalizar, queremos decir que en materia de VIH/SIDA es válido el pensamiento que orienta al Ministerio de Salud y Desarrollo Social venezolano: «La salud debe dejar de ser un privilegio de pocos, para ser un patrimonio de los pueblos». Sólo así ganaremos la batalla al VIH/SIDA.

The PRESIDENT:

Thank you, the honourable delegate of Venezuela. I assure you that WHO will take your comments and notes your achievements and your concerns.

I would like to ask the second Vice-President of the Health Assembly to take the Chair.

Mrs A. David-Antoine (Grenada), Vice-President, took the presidential chair.
Mme A. David-Antoine (Grenade), Vice-Président, assume la présidence.

Le Professeur REDJIMI (Algérie) :

Madame le Président de séance, Monsieur le Directeur général, Honorable assistance, Mesdames et Messieurs, permettez-moi tout d'abord de féliciter le Président pour son élection à la tête du Bureau de cette session. Permettez-moi aussi de remercier M. le Directeur général pour son remarquable exposé relatif à l'état de la santé dans le monde.

Alors que le monde entier n'a pas fini de chercher la meilleure riposte possible à la pandémie de VIH/SIDA, nous nous sommes trouvés confrontés, et le danger n'est pas encore entièrement écarté, à l'apparition d'une nouvelle maladie qui avait pris des allures de pandémie, à savoir le syndrome respiratoire aigu sévère (SRAS) ainsi qu'à la fièvre aviaire. Ce défi épidémiologique nouveau ne doit pas pour autant occulter le fait que, tous les jours, des enfants, des femmes et des hommes n'ont pas accès à des services sanitaires de base à cause non seulement de la pauvreté, mais aussi des catastrophes humanitaires induites par les conflits armés. C'est plus particulièrement le cas en Iraq et dans les territoires arabes occupés où la situation sanitaire est préoccupante et nécessite une réponse concertée de la communauté des nations dans un cadre où la morale et le droit puissent retrouver leur juste place.

Lors des différentes réunions régionales et internationales relatives à la problématique du VIH/SIDA en Afrique et qui faisaient suite aux recommandations du sommet de l'OUA tenu à Alger en 1999, les Etats africains avaient été unanimes à dire que le traitement de cette tragédie, qui frappe durement notre continent, ne saurait se suffire d'une simple approche médico-sanitaire tant les facteurs économiques et politiques pèsent de tout leur poids dans le développement de cette pandémie. Il est d'ailleurs regrettable de constater qu'une part infime du budget consacré à l'armement et à l'industrie de guerre de certaines « grandes puissances ou grandes nations civilisées » suffirait à financer durablement toute la lutte contre le SIDA en Afrique. Les chiffres que vient de rendre publics notre Organisation sont effrayants : rien que pour l'année 2003, 3 millions de personnes sont mortes du VIH/SIDA. Par ailleurs, et alors qu'elle ne représente que 11 % de la population mondiale, l'Afrique occupe la première place avec 66 % du nombre total de cas de SIDA-maladie. Quoique considérée comme un pays à faible prévalence, l'Algérie a mis en place depuis 1988 un plan national de lutte contre les MST/SIDA qui repose sur quatre axes : la prévention, la formation, la surveillance et les soins, et la réduction de l'impact du SIDA sur les dépenses de santé. Malgré la faible prévalence de cette maladie dans mon pays, la création depuis 1996 de six centres de référence VIH/SIDA pour la prise en charge et le suivi des séropositifs et des malades tant au plan biologique que clinique et thérapeutique a montré que l'accès aux traitements existants revient très cher et représente une part importante du budget consacré à cette pathologie. Que dire alors de la majorité des autres pays africains dont les ressources sont moindres et qui connaissent des taux de prévalence autrement plus élevés !

Mesdames et Messieurs, la solidarité internationale qui se manifeste en matière d'accès aux traitements et qui doit se développer davantage sur des bases plus réalistes et en phase avec l'éthique de la nécessaire solidarité avec les populations démunies ne devra pas être exclusive des autres actions qui nécessitent, elles aussi, un partenariat solidaire. Nous estimons ainsi qu'il est important de mettre en place des centres régionaux équipés de laboratoires performants en mesure d'assurer la référence diagnostique et épidémiologique de l'infection à VIH/SIDA ; des centres en mesure d'initier la recherche fondamentale et clinique et d'aider les travaux en cours. L'Algérie est disposée à participer activement à toutes ces actions dans le cadre d'un partenariat multilatéral. Il est en effet temps de travailler ensemble pour mettre en place un partenariat global orienté vers un ensemble d'actions définies localement. A ce propos, nous estimons que l'initiative du Nouveau Partenariat pour le Développement de l'Afrique (NEPAD) est le cadre privilégié pour une telle mobilisation internationale.

Pour que l'action sanitaire soit performante, efficace et durable, il est indispensable que le monde développé agisse sur les facteurs aggravants ; je pense plus particulièrement au poids de la dette qui obère tout effort de développement et induit cette effroyable misère multiforme qui fait le lit du SIDA. A ce titre, permettez-moi de féliciter particulièrement le Président Jimmy Carter et, à travers lui, tout le Centre Carter pour le discours sensibilisateur de ce matin, un discours qui permettra, j'en suis convaincu, de catalyser tous les efforts à l'effet de faire reculer la misère et de généraliser le bien être dans les pays les plus pauvres, voie incontournable pour améliorer notre niveau de santé et être en adéquation avec les droits universels de l'homme dont la santé pour tous est l'un des fondements majeurs.

C'était là, Mesdames et Messieurs, de larges extraits de mon intervention dont l'intégralité vous sera remise par écrit. Je vous remercie.

Professor KYAW MYINT (Myanmar):

I would like to congratulate and to thank the Director-General, Dr Lee Jong-wook, for the address yesterday to the Fifty-seventh World Health Assembly, which touched on many important issues.

As the main theme of this Fifty-seventh World Health Assembly is HIV/AIDS, I will confine my statement primarily to the HIV/AIDS activities in my country. While the outbreak of new infectious diseases is of major concern and has attracted considerable attention, we should not forget the diseases that comprise the major public health problems of our region, such as malaria, tuberculosis and HIV/AIDS. Myanmar has launched a well-organized, systematic and planned

response to the HIV/AIDS problem. A national strategic plan for expanding and upgrading HIV/AIDS prevention and control activities from 2001 to 2005 is being implemented in conjunction with the United Nations and partners in the Joint United Nations Programme on HIV/AIDS (UNAIDS). Furthermore, a national strategic plan for HIV/AIDS prevention and control from 2005 to 2009 has been drawn up, which is the logical continuation of the current plan. The plan is comprehensive and organized to mobilize the political commitment and support of all stakeholders at the national level, involving all health-related ministries. Close coordination and collaboration have been established between the national AIDS programme, United Nations agencies, and international and local nongovernmental organizations. The strategic components of the national AIDS prevention and control plan are advocacy, public education, targeted prevention (especially of sexual transmission), injecting drug use, condom promotion, prevention of mother-to-child transmission, safe blood supply, and care and treatment. In Myanmar, the national AIDS programme is addressing the stigma and discrimination issues by providing educational messages not only to the general population but also to targeted populations such as youths (including out-of-school youths), mobile populations and women.

One of the most remarkable events to raise awareness was the first exhibition on HIV/AIDS prevention and control at the national level, which was held in Yangon on 3 November 2003. The exhibition was inaugurated by His Excellency the Prime Minister and attended by ministers and senior government officials, senior diplomats, and United Nations officials and heads of agencies in Myanmar. This reflects the high-level political commitment and also shows the understanding and cooperation among the related ministries, local and international nongovernmental organizations and United Nations agencies that are collectively fighting HIV/AIDS in Myanmar. Myanmar has had an established HIV sentinel surveillance system since 1992 and has subsequently expanded and strengthened the surveillance system over the years. It has also incorporated a behavioural surveillance component. Currently, the second-generation sentinel surveillance is being conducted in the country.

It is evident that combination antiretroviral therapy has extended and improved the quality of life for a large number of people living with HIV/AIDS and has transformed the perception of HIV/AIDS from one of a fatal disease to one of a treatable, chronic illness. However, prevention will remain central to all HIV interventions. As communities become aware that HIV can be both prevented and treated, attitudes will change and denial, stigmatization and discrimination will definitely be reduced. One of the most important issues in provision of antiretroviral treatment is that, as therapy is for life, we have the responsibility to ensure an uninterrupted supply of antiretroviral drugs. The Ministry of Health established clinical management of HIV/AIDS guidelines in 2002. It is currently updating the criteria for providing antiretroviral therapy to HIV-positive people and the antiretroviral treatment guidelines. In order to offer wider access to antiretroviral therapy services, voluntary confidential counselling and testing services are now being expanded to 36 sites where there are sexually transmitted diseases and AIDS control teams, maternal and child health clinics, tuberculosis clinics and drug treatment centres.

Before I end my statement, I would like to pay my tribute to Dr Samlee Plianbangchang, who is the new Regional Director for South-East Asia. I look forward to his leadership.

In conclusion, I would like to congratulate the President of the Fifty-seventh World Health Assembly and the Director-General and express my sincere appreciation to WHO and all our partners in health development for their valuable support extended to my country.

Ms HALTON (Australia):

Australia welcomes Dr Lee as the Director-General of WHO. We were fortunate to have had Dr Lee in Australia recently to open the "Health2004" World Conference on Health Promotion and Health Education. Australia strongly supports the efforts of Dr Lee and the World Health Organization to step up the global fight against HIV/AIDS. The devastation that this disease is wreaking in Africa and some other parts of the world is one of the most compelling public health crises of modern times. Australia gives high priority to efforts to combat HIV/AIDS both domestically and internationally. Although HIV/AIDS is largely under control in Australia, we cannot be complacent. The number of newly-diagnosed HIV cases in 2002 was 16% higher than the previous year. It is not yet clear whether this increase is a continuing trend.

Diseases do not recognize country borders and countries do not exist in isolation from their neighbours. It is of great concern to Australia that the Asia-Pacific region has developed the most pressing need for HIV/AIDS prevention, treatment and control outside Africa. In the Western Pacific, especially in Papua New Guinea, HIV infection is increasing rapidly. There is a danger that the epidemic will spread out of the high-risk populations where it is now concentrated, into the general population. In July 2000, Australia committed Aus$ 200 million over six years to a global HIV/AIDS initiative, and in 2001 Australia hosted the Asia-Pacific Ministerial Meeting on HIV/AIDS. In February 2004, we committed a further Aus$ 25 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Responding to the HIV/AIDS crisis requires strong public health approaches and a sustained effort. Public health leadership is needed not only across the health system but also in related areas which have an impact on health. The challenges that health systems face, such as budgetary pressures, acute care and hospital resourcing issues, and workforce availability, can quickly overwhelm prevention agendas.

Disease control, as Dr Lee has said, involves both prevention and treatment. Australia strongly endorses the WHO "3 by 5" initiative to provide antiretroviral drugs – but the fight against HIV/AIDS cannot be won without prevention and control initiatives. The WHO Western Pacific Region has done work on defining nine essential public health functions which can help ensure a comprehensive approach to HIV/AIDS in the Region, including Australia. These functions provide a framework to review and assess how well health systems are prepared to meet health challenges, considering the determinants of health, protection for a population's health, and treatment of disease. Australia congratulates Dr Omi and the staff of the WHO Regional Office for the Western Pacific on the work that has gone into the development of these essential functions and the workshop held in Fiji last December. Australia also thanks Fiji, Viet Nam and Malaysia, the other Pacific Island countries, and New Zealand for their roles in this major initiative.

The first two essential public health functions are health situation monitoring and analysis, and epidemiological surveillance. Much can be done to strengthen surveillance systems, as has been demonstrated recently by SARS.

The third function is the development of policies and planning in public health. The Australian Government is currently developing its fifth national strategy for HIV/AIDS in consultation with all relevant sectors and communities. It will give priority to indigenous Australians and interface closely with policies on sexual health, other sexually transmissible infections, illicit drugs and hepatitis C.

Fourth is strategic management of health systems and services. Implementation of an HIV/AIDS strategy requires a whole-of-system approach and an emphasis on overcoming barriers to access to programmes and services.

Fifth is regulation and enforcement to protect public health. For example, compulsory disease notification, laws against knowingly spreading HIV, and laws banning discrimination against people with HIV/AIDS.

Sixth – human resources development and planning in public health. It is not only doctors and nurses who play a critical role but also community health workers. The challenge is to ensure that treatment and services reach out even into rural and remote areas.

Seventh – health promotion, social participation and empowerment. These are best achieved – and an independent review of Australia's national HIV/AIDS strategy confirms this – if they are delivered through the community, via partnerships with government.

The eighth and ninth functions relate to ensuring the quality of health services and research, and the development and implementation of innovative public health solutions.

These essential public health functions provide a clear framework for assessing our responses to issues such as HIV/AIDS in the Western Pacific region, in cooperation with the wider international community.

We look forward to working with our neighbours to further the use of the essential public health functions and to continuing the fight against HIV/AIDS nationally and internationally.

Mr HØYBRÅTEN (Norway):

AIDS is the Black Death of our time. AIDS is close to exploding in parts of Asia and Europe. Its impact on Africa has been devastating. The global community has the means to curb epidemics like SARS. The time to give AIDS the same level of commitment and attention is now. I congratulate the Executive Board and the Director-General on putting HIV/AIDS at the top of the agenda this year. Being serious about poverty reduction and committed to the Millennium Development Goals, it is now time to demonstrate our commitment. Prevention is task number one. Taboos need to be broken; people need to know how to protect themselves, and they need condoms and other means to do so. Girls' and women's rights must be fully respected; men's violence against women completely stopped. If not, AIDS will continue its devastation.

Equal access to treatment and care is an issue of human rights and solidarity. The imbalance between rich and poor in access to treatment must be levelled. Norway fully supports the "3 by 5" initiative. It must be country-owned and go hand in hand with strengthening health systems. Last month in Washington, we took part in a breakthrough agreement on harmonization of HIV/AIDS efforts, the "Three Ones" principle. This is a major step forward in securing national ownership and accountability. In rolling out "3 by 5", outreach is imperative. Treatment must be given without discrimination. Nongovernmental organizations, churches, movements against HIV/AIDS, and not least people living with HIV and AIDS, have a crucial role to play. Experience shows that this involvement is also highly effective.

When European ministers met in Dublin in February, they committed themselves to strengthening their cooperation on HIV/AIDS. Norway takes an active part in the European Union's Northern Dimension Partnership in Public Health and Social Wellbeing. HIV/AIDS is a priority area of work. The results from the Task Force on Communicable Disease Control in the Baltic Sea Region and the Barents Health Cooperation Programme form a solid basis to build on.

Tackling poverty-related diseases such as HIV/AIDS and contributing to the Millennium Development Goals is rightly a top priority of WHO. Many developing countries have a double burden of disease, as lifestyle-related illnesses increase when economies grow. Alcohol, tobacco and unhealthy diets are major public health challenges around the world. *The world health report 2002* documents the importance of alcohol as a public health issue. Few other commodities, if any, hurt innocent third parties as alcohol does – I will only mention drunken driving, violence, and child neglect. We need to protect our children and young from the adverse consequences of alcohol. This issue must be properly addressed at global level. We ask for a stronger involvement on the part of WHO against the harm done by alcohol.

A milestone in the history of WHO was last year's adoption of the WHO Framework Convention on Tobacco Control. My country was privileged to be the first country to ratify it. I would strongly encourage all Member States to cooperate in making the Convention operational as soon as possible. Diseases related to unhealthy diet and sedentary lifestyles constitute a serious and growing health problem around the world. The Secretariat has done an excellent job in preparing the draft global strategy on diet, physical activity and health, which will be discussed today. Member States, stakeholders, and – last but not least – experts including the reference group, have provided valuable input. The draft strategy has the potential to be a great support in our national efforts and consequently my Government is prepared to give its full support. It is important for the future of our children and grandchildren to take action now. This Health Assembly has in its hands an opportunity to endorse the draft global strategy. As ministers of health, we have a clear responsibility to act on this opportunity. Let us deliver.

Mrs JAKAB (Hungary):

It is two weeks now since Hungary, together with nine other countries, joined the European Union. This is an historical event for us, which will help us to modernize our countries and to close the gaps where they exist. We look forward to working together in Europe as well as globally. WHO will certainly remain a very important partner for us, as it has always been since we joined the Organization.

In a constantly changing world, WHO's global as well as regional and local leadership is essential to tackle successfully old and new challenges which the health sector and its partners are facing in every country. I would like to use this opportunity to congratulate the Director-General on his comprehensive report. We have noted with satisfaction that during the past year, WHO has continued to play a pivotal role at the global level in fighting the many diseases and hazards humanity is facing today. I would like to express our congratulations to WHO and its leadership and applaud the Secretariat for excellent work in the areas of road safety, health sector development, prevention and control of SARS, measles, malaria, HIV/AIDS, and many other communicable diseases. WHO's contribution to promoting healthy lifestyles, preventing maternal and infant death and improving reproductive health, and finding new ways to distribute the results of research is also highly praiseworthy. I fully agree with the view that WHO's most important input has to be made at country level; the WHO country offices should be the real focus of its activities. For this reason, it is very encouraging that the leadership of the Organization has initiated very extensive and systematic work to decentralize the Organization's functions and strengthen WHO's presence in Member countries. I fully support the Director-General's plan to shift financial and technical resources to country offices. This will enable country staff to perform more ably and provide more effective and efficient support to governments. Stronger country presence will definitely help maintain and expand WHO's leadership in the health field. At the same time, let me point out that WHO's competitive edge has always been its development work; this is what added value to the technical work at country level and therefore it should continue.

Hungary strongly supports the call for increased international collaboration to prevent and cure AIDS and care for those infected with HIV. The "3 by 5" initiative, as part of the fight against the spread of HIV/AIDS, is a very important element of WHO's efforts. It is also important though, that HIV/AIDS activities go hand in hand with other activities that are necessary to improve the health of the people in Member States. Although there is a need to maintain a balance in providing WHO support to various areas of health, the exceptional nature of the HIV/AIDS crisis certainly justifies special attention. It is in this context that we welcome *The world health report 2004. Changing history* and, furthermore, welcome an increased leadership role of WHO in this area.

Hungary has always benefited greatly from WHO's support and we are looking forward to continued collaboration to enhance our national initiatives. Our national public health programme, adopted by our Parliament a year ago, aims to improve the life expectancy of Hungarians by at least three years within the next 10 years. It is our strong intention to close the gap in this area. We are looking forward to close cooperation with both the European Union and WHO in this field. Another excellent example of our partnership with WHO is the upcoming Fourth Ministerial Conference on Environment and Health to be held in Budapest in June this year. With the full support of the WHO Regional Office for Europe and the Regional Director personally, Hungary will be hosting this Conference next month. Environmental problems are numerous and very serious in Europe, and this Conference will without doubt help to solve those problems. The Conference is exceptionally important for our future, as it will be focusing on our children. Children are the most vulnerable to environmental hazards. At the same time, they are the ones who are the foundations of the future of our countries. Therefore the well-being of our children is fundamental to, and of paramount importance for, any future development in Europe. We also believe that global cooperation is needed for the fight against noncommunicable diseases. This is why my country was one of the first to sign and ratify the WHO Framework Convention on Tobacco Control. We also welcome the draft global strategy on diet, physical activity and health as well as the draft resolution on health promotion and healthy lifestyles.

In the future, Hungary will remain a deeply committed partner of WHO; above all, we will continue our traditional cooperation with the WHO Regional Office for Europe. We are convinced that WHO, under your strong leadership, Director-General, will effectively and efficiently contribute to the betterment of the health of the world and therefore our efforts to achieve a better and healthier future for humanity, in close partnership with WHO, will have an even greater impact.

Dr PEZESHKIAN (Islamic Republic of Iran):

Bismillah arrahman arrahim.

HIV/AIDS has evolved into a social, economic, cultural and psychological dilemma, affecting every aspect of human life. Today it is the most serious threat to human health. Due to its extent and manner of causing infection, its fatal outcomes and its long symptom-free period, it is considered as one of the top health priorities in the whole world, including in the WHO Eastern Mediterranean Region. In our campaign against HIV/AIDS, we must address the root causes of the HIV/AIDS pandemic. In this perspective, promotion of religious and ethical norms and values of communities should be considered as a cornerstone for our national plans on prevention and control of HIV/AIDS.

We are deeply concerned about HIV/AIDS in our region. Although the WHO Eastern Mediterranean Region remains the least affected, there are indications that infection is expanding, especially among high-risk groups such as injecting drug users. The dual epidemics of tuberculosis and AIDS form a deadly partnership, each reinforcing the other. Together they have become the most serious threat to public health in the poorest countries of the world. This is particularly alarming, as one third of the 42 million people living with HIV/AIDS are also infected with *mycobacterium tuberculosis*. According to WHO, globally 6 million people have tuberculosis and at the same time are infected with HIV. As a result, every year 250 000 HIV-infected persons die because of tuberculosis. The most practical way of dealing with the dual epidemic is to adopt a dual strategy, requiring equal commitment and close coordination and collaboration between the two programmes to prevent tuberculosis and HIV/AIDS. This calls for high-level political commitment, strong leadership and good communication at all levels of operation.

In our fight against HIV/AIDS we should concentrate on combating HIV/AIDS-related stigma and discrimination, which rank among the most serious and most pervasive barriers to an effective response to the AIDS epidemic. In fact, stigma and discrimination increase people's vulnerability; isolating people and depriving them of the necessary treatment, care and support only worsens the impact of infection. Pending the discovery of an effective vaccine against HIV/AIDS, we should make the best use of the existing technology, including the available interventions. One of the most important lessons of recent years is the need for integrated AIDS prevention and care. Widespread access to antiretrovirals may help to destigmatize the disease and thereby improve demand for voluntary counselling and testing. Iran is among the countries in which the HIV/AIDS epidemic has been concentrated in at least one high-risk population. That is to say, its spread has been more than 5% within one social group and less than 1% among pregnant women, who represent the index for the general population. Care and support for people living with HIV/AIDS in Iran include medical outpatient treatment in triangular clinics, inpatient therapy, and counselling, which are all provided free of charge and mostly carried out by the government sector. The treatment protocol consists of triple therapy, and antiretroviral drugs are subsidized by the Government. Of all the people living with HIV/AIDS in need of antiretroviral drugs, 25% are receiving treatment. Voluntary counselling and testing facilities have been established in 20 provinces and 21 prisons with a high prevalence of HIV infection. A national strategic plan on HIV/AIDS has been developed since 2001 and a surveillance system for HIV/AIDS and sexually transmitted infections has been integrated into the national health surveillance system. It relies on case reporting and serologic studies. The national HIV/AIDS control programme has been integrated into the primary health care system. This includes information, education and communication activities, harm reduction, voluntary counselling and testing, and care and treatment. An agreement between the prison organization and the Ministry of Health and Medical Education regarding the management of HIV/AIDS, hepatitis and tuberculosis patients has resulted in excellent cooperation between the health sector and the prison organization.

The scourge of HIV/AIDS is a multifaceted issue with serious socioeconomic consequences. Our fight against AIDS calls for global solidarity, top-level political commitment and strong community involvement. We must win the battle. Defeating AIDS may be difficult, but it is certainly not impossible.

El Dr. MUÑOZ PORRAS (Chile):

Señora Vicepresidenta, señoras y señores delegados: Chile se presenta hoy ante esta Asamblea con la convicción de estar haciendo todo lo posible por llevar adelante una reforma de su sistema de salud dirigida a introducir mayor equidad en el acceso y eficiencia en las acciones dirigidas al enfrentamiento de los problemas de salud de la población.

Nuestra reforma pretende alcanzar objetivos sanitarios de mediano plazo: en primer lugar queremos seguir avanzando en lo alcanzado hasta ahora. Nuestra mortalidad infantil para el año 2002 ha llegado a la cifra de 7,8 por 1000 nacidos vivos y sabemos que cada vez será más difícil seguir bajando los riesgos de morir de madres e hijos, por lo que se requiere un esfuerzo redoblado y dirigido para profundizar en estos logros. En segundo lugar, queremos ser eficaces en el enfrentamiento de los desafíos propios de nuestra realidad demográfica y del modelo de sociedad que construimos. Se trata de enfrentar el severo riesgo de morbilidad y mortalidad prematura derivado de los altos índices de obesidad, sedentarismo, hipertensión, traumatismos, tabaquismo y abuso de alcohol que se aprecia en nuestra población y que recientemente hemos comprobado fehacientemente en nuestra primera encuesta de prevalencia de enfermedades. En tercer lugar, queremos introducir más equidad en el acceso a la salud, tanto en la esfera de la atención médica como en la de la salud pública y, finalmente, queremos entregar a la población servicios de salud de calidad y efectividad probadas.

Nuestras herramientas privilegiadas para alcanzar estos objetivos son, por una parte, un plan de salud pública que aborde prioridades para la salud con metas definidas y alcanzables en plazos razonables gracias a la implementación de intervenciones cuya efectividad haya sido demostrada por la evidencia existente y, por otra, la puesta en marcha de un régimen de garantías de salud que explicite los derechos de chilenas y chilenos en materia de oportunidad, calidad y protección financiera para el enfrentamiento de los problemas que son responsables de la mayor parte de la carga de enfermedad del país.

Los temas principales de interés para esta Asamblea son abordados en Chile en esta doble dimensión. Frente al VIH/SIDA, por ejemplo, abordamos la prevención a través de la educación y comunicación masivas, de la promoción del uso de preservativos y de la sexualidad responsable y, en el plano de la atención médica, lo hacemos garantizando el acceso a tratamiento antirretroviral al 100% de las personas que viven con el virus. La colaboración que hemos recibido del Fondo Mundial de Lucha contra el SIDA, la Tuberculosis y la Malaria nos ha ayudado a adelantar esta garantía, cuya sustentabilidad está asegurada por el creciente presupuesto que el país dirige al control de este importante problema de salud.

En materia de enfermedades crónicas no transmisibles, nos preocupa garantizar el acceso de las personas a los modernos tratamientos existentes, pero, al igual de lo planteado en el informe del Consejo Ejecutivo sobre el tema de la alimentación, estamos convencidos de que no será posible abordar el control si no somos capaces de educar a nuestra población y cambiar sus hábitos alimentarios y de ejercicio físico. Saludamos el informe de la Secretaría y manifestamos nuestro apoyo a medidas regulatorias basadas en la educación de la población acerca de los riesgos del consumo excesivo de azúcares, sal y grasas de mala calidad, para lo cual es indispensable informar acerca del contenido de estas sustancias en los alimentos de uso masivo. El camino de la alimentación saludable será largo, pero exitoso al final si somos constantes y firmes como lo hemos sido frente a otros factores de riesgo relevantes.

Señora Vicepresidenta, señoras y señores delegados: la salud es una prioridad política superior del Gobierno del Presidente Ricardo Lagos, lo que se manifiesta en la decisión de abordar una reforma difícil pero imprescindible. Como ya lo hiciera el país con su sistema económico, su educación, su justicia y su servicio civil, esperamos ser exitosos gracias al esfuerzo por ser eficientes en el uso de los mayores recursos destinados a estas prioridades. Esperamos también profundizar la cooperación internacional con nuestros vecinos de América y con los países agrupados en la Organización Mundial de la Salud. Chile felicita al Director General por su decisión de avanzar en grandes prioridades de salud pública y lo insta a no abandonar los esfuerzos por contar con sistemas de salud cada vez más justos y eficientes.

Le Dr TOIKEUSSE (Côte d'Ivoire) :

Madame le Président de séance, Excellences, Mesdames et Messieurs les Ministres, Monsieur le Directeur général, honorables délégués, Mesdames et Messieurs, je voudrais, au nom du Président de la République de Côte d'Ivoire, au nom du Gouvernement de Réconciliation nationale et en mon nom propre, vous exprimer ma gratitude pour l'occasion qui m'est offerte de prendre la parole devant cette auguste Assemblée. Je souhaiterais adresser mes vives félicitations au Ministre de la Santé du Bangladesh pour la bonne conduite des travaux de la Cinquante-Sixième Assemblée mondiale de la Santé. Mes chaleureuses félicitations vont également au Président, et à son pays, le Pakistan, pour sa brillante élection à la présidence de la Cinquante-Septième Assemblée mondiale de la Santé. Je suis persuadé que sa longue et solide expérience sera un gage pour le bon déroulement de nos travaux. Pour sa part, la délégation de la Côte d'Ivoire, venue en grand nombre, ne ménagera aucun effort pour vous apporter son appui et sa contribution. Je voudrais, enfin, adresser mes vives et chaleureuses félicitations au Dr LEE Jong-wook, Directeur général de l'OMS, et lui affirmer tout le soutien et la disponibilité la plus totale de la Côte d'Ivoire dans l'accomplissement de sa mission. Je souhaiterais lui témoigner particulièrement ma gratitude pour les appuis considérables et le soutien précieux dont mon pays bénéficie de la part de l'OMS.

Je suis heureux de m'adresser à cette auguste Assemblée pour exposer la situation sanitaire de mon pays et partager avec vous notre vision de la santé sur notre planète. Outre les conséquences immédiates engendrées au plan humanitaire par le conflit armé dont la Côte d'Ivoire sort progressivement avec l'aide de tous, il ne fait pas de doute qu'après 19 mois de guerre, les déséquilibres profonds de l'ensemble du dispositif sanitaire ivoirien sont réels et constituent une menace sérieuse pour la santé des populations, en particulier celle des plus vulnérables : les enfants et les femmes, mais aussi les déplacés de tous sexes et de tous âges. C'est pourquoi, outre le thème central de cette Cinquante-Septième Assemblée mondiale de la Santé, qui porte sur le VIH/SIDA, mon propos s'intéressera aussi à la poliomyélite et à la sécurité routière, thèmes tous contenus dans les objectifs du Millénaire pour le développement, sans négliger bien évidemment le paludisme et la tuberculose. L'infection à VIH/SIDA reste préoccupante en Côte d'Ivoire avec la présence des deux virus en cause (VIH1 et VIH2) ; une séroprévalence globale de 10 % : plus de 126 000 personnes ayant besoin d'antirétroviraux ; et 600 000 orphelins du VIH/SIDA. Grâce à l'aide de nombreux partenaires que je félicite, la Côte d'Ivoire s'apprête à mettre en oeuvre la stratégie « 3 millions d'ici 2005 » de l'OMS. La lutte implacable contre la pandémie du VIH/SIDA doit s'intégrer dans la lutte globale contre la pauvreté. L'engagement personnel du Président de la République dans ce combat s'est traduit par la création, le 24 janvier 2001, d'un ministère chargé spécifiquement de la lutte contre cette pandémie. L'appui accru de l'OMS, de l'ONUSIDA, du Fonds mondial, du Plan d'urgence pour la lutte contre le VIH/SIDA proposé par le Président des Etats-Unis d'Amérique et de toutes les initiatives bilatérales est plus que jamais nécessaire pour la réalisation des progrès attendus. Une meilleure coordination de toutes les activités et l'assouplissement des procédures de mobilisation des ressources sont le gage du succès de notre entreprise commune.

En ce qui concerne la poliomyélite, la République de Côte d'Ivoire a repris en 2004 l'organisation des journées nationales de vaccination après une interruption de deux ans du fait de la guerre, laquelle interruption a occasionné cinq nouveaux cas de poliomyélite qui sont tous des cas importés. C'est le lieu pour mon pays d'insister auprès de l'Assemblée mondiale de la Santé pour qu'elle amène tous les Etats Membres de l'OMS à adhérer de façon effective à la stratégie d'éradication de la poliomyélite. Nous devons refuser tous ensemble de rendre d'innocents enfants infirmes pour la vie. Le problème de la sécurité routière est aussi préoccupant. Le thème de la célébration de la Journée mondiale de la Santé cette année s'y rapportait. En Côte d'Ivoire, sur une population d'environ 17 millions d'habitants, la route a fait en 2001 765 tués, 2525 blessés graves et 11 134 blessés légers dont 40 % de piétons et 41 % d'enfants. La Côte d'Ivoire se réjouit de l'intérêt que l'OMS accorde à la sécurité routière et est résolue à faire en sorte que les accidents de la route ne soient plus une fatalité.

Madame le Président de séance, honorables délégués, en terminant, je voudrais remercier tous ceux qui ont aidé la Côte d'Ivoire dans ses efforts pour faire face à la grave crise sociopolitique aux conséquences sanitaires incommensurables. En effet, mon pays a bénéficié d'un appui fort appréciable

des partenaires bilatéraux et multilatéraux, ainsi que des organisations non gouvernementales. La Côte d'Ivoire reconnaissante sait toujours pouvoir compter sur la communauté internationale, sur l'OMS et son Directeur général, le Dr LEE Jong-wook, pour le soutien et l'assistance dont elle a besoin et qui, en réalité, ne lui ont jamais fait défaut. Je vous remercie.

Dr JIGMI SINGAY (Bhutan):

It is my honour to convey to this august gathering the warm greetings of the people of the Kingdom of Bhutan. May I congratulate Dr Lee Jong-wook on the very successful completion of his first year as Director-General of WHO and thank him for his very inspiring address.

More than ever, the world is being called to action by emergencies in health, be they natural or man-made. The World Health Organization was once again brought to the fore with challenges posed by the sudden and unexpected emergence of SARS and avian influenza. Bhutan commends WHO for dealing effectively and swiftly with these emerging health threats. We particularly take note of the strong leadership of WHO in directing the effective use of its vast technical and collaborative resources.

We are gathered here not only to acknowledge the successes in dealing with such emerging global health threats, but also to commit ourselves to continuing our collective efforts to deal with the many urgent health concerns that plague the world today. The "3 by 5" initiative launched by the Director-General is indeed a bold and innovative step. Millions continue to fall victim to the ravages of HIV/AIDS and better access to antiretrovirals would certainly improve the quality of life and longevity of those infected. However, implementing "3 by 5" is by no means without challenges, the most important being the sustainability of such a programme. From the little experience that we have in dealing with this challenge, a comprehensive mix of prevention, care and treatment is critical. The emphasis on the treatment of what is essentially a preventable disease should not make us forget the importance of ensuring the availability of resources for preventive programmes. Since the late 1980s, long before detecting a single HIV-positive case, Bhutan launched an aggressive preventive programme on HIV/AIDS. I am pleased to inform you that, with a grant from the World Bank, we are now set to intensify our preventive and promotional programme and, at the same time, to ensure universal access to treatment for those living with HIV/AIDS.

I would also like to take this opportunity to commend the efforts of WHO to bring into force the landmark WHO Framework Convention on Tobacco Control. Bhutan remains fully committed to implementing the provisions of the Framework Convention. The Royal Government will ratify the protocol during its parliamentary session this coming July.

It is very heartening to note that decentralization and strengthening of WHO's country support is one of the major thrusts among the many notable initiatives of the new Director-General of WHO. Bhutan welcomes such initiatives and supports changes which will enhance the efficiency, effectiveness, and accountability of the Organization.

In conclusion, Bhutan is fully committed to working closely with the other Member States of WHO towards achieving the Millennium Development Goals and targets and translating them into concrete action. I firmly believe that this will ensure a healthier tomorrow for our peoples.

La Dra. MAZZETTI (Perú):

Señora Vicepresidenta: en primer lugar quisiera unirme a quienes me han precedido en el uso de la palabra para felicitar a usted y a los distinguidos miembros de la Mesa por su elección para dirigir los trabajos de esta Asamblea Mundial de la Salud. Quisiera asimismo, a través de su intermedio, dirigirme al Director General de la OMS, Dr. Lee, y expresarle el reconocimiento del Perú por su liderazgo e importantes iniciativas que ha fomentado, entre las cuales se encuentra uno de los retos más arduos y urgentes que enfrenta la historia de la humanidad en materia de salud: la lucha contra la pandemia del VIH/SIDA.

El Perú aplaude la intensificación en la OMS de una estrategia integrada mundial que vincule la prevención, la atención y el tratamiento, dando prioridad a las poblaciones más pobres y desatendidas

y, en ese sentido, apoya decididamente la campaña lanzada por el Director General con el fin de extender el tratamiento del VIH/SIDA a tres millones de pacientes para el año 2005.

Señora Vicepresidenta: en el Perú la infección por VIH/SIDA se encuentra en un nivel de epidemia concentrada. No obstante, somos conscientes que si no la atacamos debidamente, esta enfermedad podría tener efectos explosivos tanto en nuestro país como en el resto de países de la región. Con el objetivo de atender a los 13 000 peruanos seropositivos que requieren terapia antirretroviral y que no tienen la capacidad de acceder a la misma, el Perú suscribió en octubre último un acuerdo de asistencia financiera con el Fondo Mundial de Lucha contra el SIDA, la Tuberculosis y la Malaria. En ese marco, gracias a un enorme esfuerzo por parte del Gobierno peruano y al apoyo del Fondo Mundial, hace poco menos de una semana se ha dado inicio al tratamiento de 1000 personas afectadas, y se espera culminar el presente año con 3000 pacientes en tratamiento.

Contribuyen al esfuerzo del Estado peruano en la lucha contra el SIDA: 1) el sistema DOTS para la lucha contra la tuberculosis, cuyo modelo de aplicación en el Perú ha sido reconocido a nivel mundial y cuya experiencia en adherencia ha enriquecido a los grupos de tratamiento para VIH/SIDA; 2) el apoyo al cumplimiento mediante los agentes de soporte personal, familiares, allegados de las personas beneficiadas y promotores de salud. Ello nos permite compensar la falta de personal de salud; 3) la participación de la sociedad civil organizada, experiencia enriquecedora para el Ministerio de Salud, mediante el Comité Nacional Multisectorial de Salud, que involucra varias instituciones civiles, así como personas que viven con SIDA y tuberculosis; y 4) la negociación para adquirir medicamentos antirretrovirales en forma colectiva, que ha disminuido significativamente el costo anual del tratamiento, permitiendo su acceso a mayor cantidad de personas.

Señora Vicepresidenta: si bien reconocemos la prioridad del tratamiento de la enfermedad, no debemos olvidar que el VIH/SIDA es un tema de salud, pobreza y desarrollo. En este contexto, las acciones de prevención y promoción, y la lucha contra la estigmatización, tienden a dejarse de lado en países como los nuestros ya que carecemos de los recursos necesarios para ello.

Es por esa razón que quisiera hacer una invocación para que a nivel internacional se continúen los esfuerzos en la búsqueda de financiamiento específico para que los países con desarrollos heterogéneos no perdamos de vista e impulsemos las medidas de prevención y promoción en VIH/SIDA. Para ello es esencial establecer asociaciones estratégicas entre todos los gobiernos, organismos internacionales, instituciones financieras internacionales, donantes, sector privado y sociedad civil, en donde cada uno de estos actores comparta y asuma responsabilidades específicas.

Igualmente, quisiera llamar la atención de los países que como el nuestro hacen grandes esfuerzos por alcanzar los objetivos de salud plasmados en la Declaración del Milenio, para que tengan en cuenta la repercusión de los tratados internacionales que involucran directa o indirectamente patentes y políticas de medicamentos esenciales o genéricos, ya que existe el riesgo de limitar e inclusive disminuir el número de personas que acceden a tratamiento antirretroviral, al igual que el acceso a otros medicamentos. Es por ello que se requiere tomar medidas para proteger la salud pública e involucrar el apoyo de la Organización Mundial de la Salud para profundizar el análisis de esta situación y las medidas de protección.

Señora Vicepresidenta: en el Perú estamos intentando integrar de manera más directa la importante dimensión de los derechos humanos a las políticas de salud pública. Es por eso que el Gobierno peruano saluda la visita que realizará a nuestro país el Relator Especial de la Comisión de Derechos Humanos sobre el Derecho a la Salud, Sr. Paul Hunt, a inicios de junio del presente año. Conocemos del rigor y el compromiso del Sr. Hunt con su mandato. Vemos con interés el enfoque innovador que otorga a su trabajo y saludamos la relación conceptual que él establece entre el derecho a la salud y otros asuntos centrales en la actual agenda internacional tales como la salud y el comercio, el acceso a medicamentos y la salud reproductiva.

Antes de concluir, señora Vicepresidenta, quisiera rendir un homenaje a la Organización Mundial de la Salud por el ideal ético que inspira su labor desde que fue creada: lograr que todos los pueblos del mundo alcancen el nivel más alto de salud posible. Entre los hitos logrados por la OMS se encuentra el Convenio Marco para el Control del Tabaco, que constituye el primer tratado internacional en materia de salud pública, y que nuestro país ha suscrito en abril último.

Finalmente, quisiera dar la bienvenida al compromiso anunciado el día de ayer por el Director General de la OMS para priorizar en el año venidero dos metas de salud primordiales para los países

en desarrollo: mejorar la salud materna y reducir la mortalidad infantil. Sobre estos dos aspectos queda mucho por hacer y alentamos a la OMS para que refuerce la cooperación con los países para desarrollar estrategias y planes nacionales que permitan alcanzar estos objetivos.

Dr INSANOV (Azerbaijan):
Д-р ИНСАНОВ (АЗЕРБАЙДЖАН):

Прежде всего хочу от имени делегации Азербайджана поздравить Председателя Пятьдесят седьмой сессии Ассамблеи здравоохранения г-на Мохамеда Насир Хана, его заместителей и других должностных лиц в связи с избранием на высокие посты Ассамблеи.

Уважаемая г-жа Председатель, уважаемый Генеральный директор, уважаемые дамы и господа.

В своем глубоко содержательном докладе Генеральный директор Всемирной организации здравоохранения д-р Ли подверг углубленному анализу многие сферы, затрагивающие глубокие процессы охраны здоровья людей на глобальном уровне, определив при этом магистральные пути к решению ключевых задач общественного здравоохранения на сегодня и ближайшую перспективу.

Для достижения столь высоких целей исключительно важным представляется создание гибкой региональной политики с четким обозначением контуров страновых задач. Именно такая формула используется в Европейском регионе при реализации таких сложных задач, как ликвидация полиомиелита, борьба с малярией, туберкулезом, элиминация кори и многих других. В этой связи трудно переоценить организационную роль Европейского регионального бюро и лично его директора д-ра Марка Данзона. Внедрение стратегии "Адаптация услуг к потребностям" позволило через призму дифференцированного подхода к решению страновых задач добиться высоких показателей и достижения общеевропейских целей. Ярким подтверждением этому служит совместная деятельность Всемирной организации здравоохранения и правительства Республики Азербайджан.

К началу 1990-х годов прошлого столетия в Республике сложилась крайне тяжелая эпидемиологическая ситуация. Из зарегистрированных в Европе 360 случаев полиомиелита 182, или более 50%, приходилось на долю Азербайджана. Интенсивный показатель по заболеваемости дифтерией и малярией был самым высоким среди европейских стран.

Разработка и внедрение совместных стратегий, вовлечение в партнерство внешних доноров, международных организаций при высокой политической воле бывшего Президента Азербайджана Гейдара Алиева и нынешнего Президента г-на Ильхама Алиева, и мобилизации медицинской общественности обеспечили достижение высоких конечных результатов.

И если сегодня мы говорим о победе над полиомиелитом в Европе, то считаем ее своей двойной победой. Уже несколько лет в стране не регистрируются случаи дифтерии, столбняка, коклюша. Более чем в 27 раз снижена заболеваемость малярией.

И все это достигнуто за какие-то 8-10 лет, то есть за исключительно малый период в историческом измерении.

Достигнуты определенные успехи и в борьбе с туберкулезом. Согласно рекомендациям Всемирной организации здравоохранения, на всей территории страны внедрена программа ДОТС, появилась тенденция к снижению заболеваемости.

Министерство здравоохранения Республики продолжает начатую в этом направлении работу, и я считаю, что ВОЗ, как и прежде, сыграет решающую роль в обеспечении контроля над туберкулезом.

В области профилактики борьбы со СПИДом при поддержке ВОЗ был разработан национальный Стратегический план по профилактике и борьбе со СПИДом. С большим энтузиазмом страна подготовила этот план и обратилась в Глобальный фонд за поддержкой.

По рекомендации ВОЗ был осуществлен переход на 10-е издание Международной классификации болезней. При поддержке ВОЗ разработаны Национальная политика по алкоголю на 2002-2010 гг., проект Национального формуляра лекарственных препаратов, Национальная программа по контролю над табаком, подготовлен Национальный план

устойчивого финансирования программы иммунизации, разрабатывается стратегия по школам укрепления здоровья.

Проводимая в Республике реформа здравоохранения успешно продолжается, и имеются положительные результаты в развитии общественного здравоохранения.

Следуя принципам Саммита тысячелетия, правительство Республики Азербайджан разработало Стратегию снижения бедности, которая была принята в октябре 2002 года. В принятой Стратегии важнейшее значение отводится сектору здравоохранения, и мы активно включились в практическую реализацию этого стратегического документа. Учитывая тот факт, что три из семи Целей тысячелетия непосредственно связаны со здоровьем людей, перед Министерством здравоохранения стоят нелегкие задачи, но мы уверены в успешном их решении.

В завершение своего выступления хочу выразить уверенность в дальнейшем укреплении партнерских отношений между ВОЗ и правительством Азербайджана во имя и на благо охраны здоровья людей – ценнейшего из достояний мировой цивилизации.

Уважаемые коллеги.

Желаю вам крепкого здоровья, счастья, успехов и благополучия.

Dr MAMYTOV (Kyrgyzstan):
Д-р МАМЫТОВ (КЫРГЫЗСТАН):

Уважаемая г-жа Председатель.

Я тоже, как все ораторы, хочу поздравить моего друга Насир Хана с избранием на высокий пост Председателя Пятьдесят седьмой сессии Всемирной ассамблеи здравоохранения. Желаю успеха в большой и ответственной работе.

Г-н Генеральный директор в своем обширном докладе поднял очень важные вопросы для системы здравоохранения. Но я хотел бы остановиться только на проблемах СПИДа в нашей стране.

Начало века Кыргызстан встретил как страна с низким распространением ВИЧ-инфекции, но изменившаяся ситуация в последние три года вызывает сильную тревогу. Из общего числа зарегистрированных ВИЧ-инфекций 85% составляют потребители инъекционных наркотиков. Учитывая не уменьшающееся количество провоза через Кыргызстан контрабандных наркотиков, трудно говорить о стабилизации эпидемии ВИЧ/СПИДа. Но в стране эта ситуация оценивается как реалистичная и находится под контролем. Со времени начала регистрации первых случаев инфекции принят ряд важных политических решений. У нас уже принят Закон о профилактике СПИДа в Республике Кыргызстан. Правительство Кыргызстана, при поддержке Объединенной программы Организации Объединенных Наций по ВИЧ/СПИДу и других международных организаций, разработало и начало претворять в жизнь национальные программы противодействия эпидемии, которые непрерывно пересматриваются и совершенствуются.

Эти профилактические программы разработаны с учетом мирового опыта борьбы с эпидемией и основаны на многосекторальном подходе, который прежде всего фокусируется на профилактике передачи ВИЧ среди наиболее уязвимых групп населения: потребителей инъекционных наркотиков, секс-работниц, мужчин, вступающих в сексуальные отношения с мужчинами, заключенных и молодежи.

В стране реализуются вмешательства по доставке различным группам населения информации, образовательных программ, снабжению презервативами, обмену шприцев, игл для потребителей инъекционных наркотиков.

Впервые в Центральноазиатском регионе в Кыргызстане эти больные - потребители инъекционных наркотиков – получили доступ к заместительной терапии метадоном.

Выполняя Государственную программу по профилактике СПИДа и инфекций, передающихся половым путем, и наркомании, свои ведомственные программы разработали Министерство внутренних дел, Министерство юстиции, Министерство труда и социальной защиты, Министерство обороны и Духовное управление мусульман.

Деятельность Кыргызстана по сдерживанию эпидемии ВИЧ/СПИДа осуществляется в открытом взаимодействии прежде всего со странами СНГ. В настоящее время выполняется программа неотложных мер государств - участников Содружества независимых государств по противодействию эпидемии ВИЧ/СПИДа. Однако мы также нуждаемся в поддержке европейских стран по внедрению этой программы.

Особые надежды мы связываем с получением гранта Глобального фонда по борьбе против СПИДа, туберкулеза и малярии и выражаем свою благодарность его Секретариату. Первые деньги по компоненту СПИДа в размере 283 000 долл. США уже поступили в страну.

Объем всего гранта по компоненту СПИДа составляет 17 млн. долл. США на пять лет. На первые два года выделено около 5 млн. долл. США. Эти деньги будут направлены на расширение профилактических программ и целенаправленное решение многих проблем, связанных с ВИЧ/СПИДом.

Мы понимаем, что это большая ответственность для страны и, вместе с тем, огромный шанс приостановить дальнейшее развитие эпидемии.

Мы поддерживаем инициативу ВОЗ "3 к 5".

В заключение я хочу заверить, что Кыргызстан берет на себя обязательство по расширению национальных ответных мер на эпидемию ВИЧ/СПИДа, что будет вкладом для общего глобального решения этой проблемы.

Большое спасибо за внимание.

السيد سعيد دروزة (الأردن):

Mr DARWAZAH (Jordan):

بسم الله الرحمن الرحيم،

السيد الرئيس، السيد المدير العام، أصحاب المعالي والسعادة رؤساء وأعضاء الوفود، سيداتي سادتي، يسعدنا أن نتقدم لكم سيادة الرئيس، أنتم والسادة نوابكم، بأجمل التهاني لانتخابكم لهذه المناصب الرفيعة متمنياً لكم كل التوفيق والنجاح في تحقيق المهام الموكلة إليكم، وأنتهز هذه الفرصة لأتقدم إلى سعادة المدير العام بالتهنئة على تقريره الممتاز.

السيد الرئيس، إن التركيز على الأيدز كمحور مناقشات في هذه الدورة يعتبر من الأهمية بمكان إذ إننا نواجه وباء غاية في الخطورة لم يحدث أن واجه العالم مثله حتى الآن. وإن هذا الوباء كما تعلمون أدى إلى حدوث الملايين من الوفيات ومعدلات انتشاره في ارتفاع مستمر في دول عديدة من العالم. إننا نواجه كارثة حلت آثارها المدمرة في بلدان عديدة وأدت بالتالي إلى تحطيم آمال ملايين البشر وإضاعة جهود مضنية من أجل التنمية وتحسين نوعية الحياة. كذلك تسبب انتشار هذا الوباء في عودة انتشار الأمراض التي كانت قد تقلصت معدلاتها بسبب تحسن الظروف المعيشية والخدمات الصحية وبدأ الناس ينظرون إليها كأمراض تاريخية مثل مرض السل الذي يمثل حالياً مشكلة جسيمة تواجه شعوب العالم. إن المشكلة الاجتماعية الحقيقية التي نتجت عن وفيات نتيجة هذا المرض تتمثل في آلاف حالات الأطفال الذين يعيشون بلا آباء وأمهات يرعونهم وهذا بالتالي أدى إلى ارتفاع حالات التشرد والجنوح بين أطفال فقدوا الرعاية والحنان وهم بحاجة إلى برامج اجتماعية تساعدهم وترعاهم.

السيد الرئيس، إن حكومة المملكة الأردنية الهاشمية تثّمن عالياً المبادرة الدولية لعلاج ثلاثة ملايين مريض قبل نهاية عام ٢٠٠٥ باعتبارها وسيلة من شأنها أن تساعد على تعزيز النظم الصحية على نحو شامل وذلك عن طريق دعم برامج معالجة المصابين ورعايتهم. ونحن في الأردن، على الرغم من كوننا من الدول ذات معدلات الإصابة المتدنية بهذا المرض، إلا أننا ندرك بكل أمانة أن العوامل المتوفرة محلياً تساعد على حدوث ارتفاع في هذه المعدلات ما لم نتبنّ استراتيجية المكافحة حسب التوصيات العالمية بهذا الخصوص. ولقد قامت حكومة بلدي بمحاولة الوصول للفئات المعرضة للإصابة وتوعيتها من خلال تأسيس مركز خاص يعنى بالإرشاد حول الأيدز ومتابعة مرضى الأيدز ومخالطيهم. ونحن نقوم بتقديم العلاج المجاني لمرضى الأيدز حسب توصيات خبراء العلاج بهدف التخفيف عن المصابين وتحسين نوعية حياتهم.

السيد الرئيس، إن تطبيق مبدأ حقوق الإنسان في التعامل مع إصابات عدوى فيروس الأيدز هو أمر أساسي، وعلينا، كحكومات ومنظمات تطوعية، أن نعمل معاً على تطبيق أبسط المبادئ في هذا المجال، ألا

وهو مبدأ معاملة هؤلاء المصابين بإنسانية، وتزويدهم بالمشورة والمحافظة على أسرارهم. كما أن النقص في العمل التطوعي الميداني في كثير من البلدان، ومن ضمنها الأردن، يدعونا إلى التركيز على هذا المفهوم وتشجيع هذا العمل من خلال الاتصال والتوعية سواء كان ذلك لصانعي القرار أو لأعضاء المنظمات التطوعية أنفسهم. وقد قامت مجموعة العمل الخاصة بالأيدز في الأردن، والتي تمثل برنامج الأمم المتحدة المشترك لمكافحة الأيدز، بإشراك المنظمات التطوعية في نشاطات مكافحة الأيدز المحلية، مما أدى إلى ظهور الاهتمام لدى هذه المنظمات للعمل مع برنامج الأيدز في الوصول للفئات المصابة والخطرة على حد سواء وإرشادها وتوعيتها. وبهذه المناسبة، فإنني أتقدم بالشكر الجزيل للصندوق العالمي لمكافحة الأيدز والملاريا والسل الذي يقوم بدعم نشاطات مكافحة الأيدز في الأردن، كما أتقدم بالشكر الجزيل لبرنامج الأمم المتحدة المشترك لمكافحة الأيدز ومنظمة الصحة العالمية، ومنظمات الأمم المتحدة الأخرى على دعمها المتواصل لهذه الأنشطة.

السيد الرئيس، يتضمن جدول أعمال هذه الدورة مواضيع غاية في الأهمية، وإنني أرجو، من خلال نقاشنا لهذه المواضيع، أن نأخذ بعين الاعتبار الدور الكبير لمنظمة الصحة العالمية ومكاتبها الإقليمية في تنفيذ التوصيات التي سوف تتمخض عنها هذه النقاشات مؤكداً في الوقت نفسه على إمكانية السير في وضع الحلول الملائمة للمشاكل الصحية الوطنية من خلال التعاون على المستويات الإقليمية. ويأتي دور المكاتب الإقليمية للمنظمة كمنسق لهذا التعاون، وقد ثبت ذلك بشكل واضح في الدور الكبير لمنظمة الصحة العالمية في تنسيق جهود مكافحة الأمراض، خاصة كما حصل بمكافحة الالتهاب الرئوي الحاد الوخيم (سارس) والتي كان لها الأثر الكبير في الوصول إلى نتائج فعالة وسريعة، لاسيما فيما يتعلق بمعرفة المسبب وطرق تشخيصه، ولعلنا مدعوون إلى أن نستمر في هذا التعاون لما فيه خير البشرية ونمائها. وفي هذا المجال، أيضاً، اسمحوا لي أن أشير إلى أن الأوضاع الصحية في كثير من بلدان العالم، والتي لاتزال تتأثر بعوامل الحروب، تتطلب من منظمة الصحة العالمية الاهتمام وتوفير الموارد اللازمة للتخفيف من آثارها. وإنني أرجو أن تعزز منظمة الصحة العالمية دورها في تقديم المساعدات اللازمة للشعب الفلسطيني، والمساعدة على تحسين أوضاعه الصحية والتي تأثرت سلبياً وبشكل واضح بالإجراءات العسكرية الإسرائيلية. وختاماً لا يسعني إلا أن أتقدم بجزيل الشكر والعرفان لمنظمة الصحة العالمية على جهودها الحثيثة والمتواصلة للنهوض بصحة الإنسان وتخفيف معاناته أياً كان موقعه، متمنياً لاجتماعاتنا كل التوفيق.

والسلام عليكم ورحمة الله وبركاته.

Professor TAG-EL-DIN (Egypt):

السيد مكي صالح (مصر):

السيدة رئيسة الجلسة، السيد المدير العام، أهنئ السيد الوزير الزميل والصديق الدكتور محمد خان برئاسة هذه الجمعية وباقي أعضاء المكتب الموقرين لانتخابهم، كما نشكر المدير العام والأمانة على ترتيب أعمالنا هذا العام كاستجابة لواقع تغير خريطة توزيع الأمراض من حيث خطورتها، إذ أصبحت الأمراض غير السارية تمثل الخطر الأكبر بالمقارنة بالأمراض السارية. ونرحب باستراتيجية المنظمة للغذاء والنشاط البدني كاستجابة طيبة في هذا الخصوص ونتطلع إلى تبنيها بعد استيفاء الإيضاحات التي تقدمت بها الدول النامية خاصة ما يتعلق منها بالآثار الاقتصادية والاجتماعية لتنفيذ الاستراتيجية ومعالجتها للأمراض غير السارية المرتبطة بنقص التغذية.

وإذ نشيد في هذا الخصوص بمبادرة نحو أسلوب حياة أفضل في المكسيك عام ٢٠٠٠ ونتطلع إلى تفعيلها فقد قمنا في مصر بمبادرة مماثلة هي "مصريون أصحاء عام ٢٠١٠". ونأمل في حصولها على المساندة المناسبة من منظمة الصحة والدول المانحة باعتبارها العمود الفقري لجهودنا الوطنية لرصد ومعالجة الأمراض غير السارية والوقاية منها ومد شبكة الرعاية الصحية لتشمل كافة الشرائح الاجتماعية وتوفير العلاج على نفقة الدولة لغير القادرين وإدراكنا في مصر للصحة النفسية ضمن برنامجنا الوطني الطموح للإصلاح الصحي في مصر. أما بالنسبة للأمراض السارية فنحن نعمل لتدعيم شبكات الرصد ومدها بالمساندة

المعلوماتية والفنية والتقنية سواء لتطوير وتحسين آليات الوقاية أو العلاج. ونـود فـي هـذا الـشأن التأكيـد خصوصاً على ضرورة تنمية التعاون الدولي بما في ذلك تبادل المعلومات ونقل التكنولوجيا لتدعيم جهود منـع انتشار الأمراض السارية والمنقولة والوقاية منها.

السيد الرئيس، لقد اتخذت الحكومة المصرية العديد من الخطوات في مجال تعزيز الإنتـاج الـوطني للأدوية في إطار من تحقيق العدالة في إتاحة العلاج من ناحية والاحترام الكامل لحقوق الملكية الفكريـة فـي مجالات الصحة العامة والدواء من ناحية أخرى. وتستهدف تلك الخطوات تشجيع الشركات الوطنية على تنمية استثماراتها في مجالات البحث والتطوير لرفع مستوى جودة الأدوية المنتجة محلياً وتنويع المنتجات واستطلاع آفاق التقنيات الجديدة لتطوير هذه الصناعة الهامة أي صناعة الأدوية. أما في مجال مكافحة التبغ فكانت مصر ضمن طليعة الدول الموقعة على الاتفاقية الإطارية كما يوشك البرلمان المـصري علـى اسـتيفاء إجـراءات التصديق على الاتفاقية التي بدأنا في تنفيذ أحكامها الأساسية في مراحل سابقة على إبرامها ونـوالي جهودنـا لمواصلة تنفيذ كافة أحكامها.

في نفس الوقت، أوشكت مصر على إعلانها دولة خالية من شلل الأطفال وهو هدف يحظى بأولويـة قصوى على قمة اهتماماتنا ونعمل على تحقيقه بكل جدية وخاصة من خلال حملات التطعيم القومية الناجحـة والالتزام القومي والسياسي على أعلى مستوى بهذه القضية الهامة.

نجتمع مجدداً، سيادة الرئيسة، هذا العام في وقت يتواصل فيه التدهور الخطيـر للأوضـاع الـصحية للشعب الفلسطيني تحت الاحتلال بسبب الممارسات غير الإنسانية وغير القانونية لقوات الاحتلال الإسـرائيلي وخاصة ما دأبت عليه من عدوان مستمر على المدنيين وهو ما أبرزته تفصيلاً تقارير المدير العام والأونـروا وغيرهما من تقارير الهيئات الطبية والإنسانية المحايدة. ونظراً لما تمثله معالجة جمعياتنـا ذات الاختـصاص الأصيل لبحث تلك الأوضاع من أهمية خاصة باعتبار أن الجمعية هي الحدث الصحي الدولي السنوي الفريـد والوحيد الذي يمكنه تعبئة العمل الإنساني الدولي للتصدي لتلك الأوضاع فإننا نؤكد على ضرورة إيفـاد لجنـة لتقصي الحقائق من قبل منظمة الصحة العالمية لتفقد التردي غير المسبوق الذي آلت إليه الأوضـاع الـصحية للشعب الفلسطيني تحت الاحتلال. وعلى جمعيتنا الخروج بقرارات نلتزم جميعاً بتنفيذها ومراقبة الالتزام بهـا من أجل غاية إنسانية سامية وهي رفع المعاناة الصحية عن الشعب الفلـسطيني تحـت الاحـتلال. إن تـوفير الرعاية الصحية للشعب الفلسطيني المحتل وخاصة النساء والأطفال هو طلب شرعي تعلقه الإنسانية في رقاب هذه المنظمة وجمعيتنا هذه ونهيب بكافة القوى الفاعلة في مجال الصحة أن تجد له المكان المناسب على قائمـة أولوياتها.

وبنفس القدر من الأهمية نؤكد على ضرورة توفير الدواء والرعاية الصحية لكل أفراد الشعب العراقي وتكريس البرامج الفاعلة لمساعدته لعبور أزمته ورصد ومعالجة التحديات الصحية التي يواجهها هذا البلد قبـل تفاقم المشكلات الصحية في العراق الشقيق على نحو تصعب مواجهته.

وفي الختام، السيدة الرئيسة، لا يفوتني أن أتوجه بالشكر للمدير العام ومعاونيه لـلأداء المتميـز فـي خدمة قضايا الصحة العامة وما قاموا ببلورته من مبادرات مهمة، منها مبادرة "٣ قبل ٥" ومبـادرة الأنـشطة الصحية إبان الكوارث. كما نشكر مدير المكتب الإقليمي لشرق المتوسط ومعاونيه علـى التعـاون الـدؤوب والتنسيق الممتاز مع السلطات الصحية الوطنية في مصر والمنطقة.

شكراً لسيادة الرئيس، وشكراً لحضراتكم، والسلام عليكم ورحمة الله وبركاته.

The meeting rose at 12:50.
La séance est levée à 12h50.

FIFTH PLENARY MEETING

Wednesday, 19 May 2004, at 14:30

President: Mr Muhammad Nasir KHAN (Pakistan)

CINQUIÈME SEANCE PLENIERE

Mercredi 19 mai 2004, 14h30

Président: M. Muhammad Nasir KHAN (Pakistan)

ADDRESS BY THE DIRECTOR-GENERAL (continued)
ALLOCUTION DU DIRECTEUR GENERAL (suite)

The PRESIDENT:

The Health Assembly is called to order. We shall resume and complete discussion of agenda item 3.

I give the floor to the delegate of Tuvalu, who will speak on behalf of the Pacific island countries: Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Nauru, Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Vanuatu and on behalf of his own country, Tuvalu.

Dr SELUKA (Tuvalu):

We meet as we fight to defeat new epidemics of the twenty-first century such as severe acute respiratory syndrome (SARS) and the avian influenza virus. However, HIV/AIDS, which is the last major new disease of the twentieth century, is still very much with us, devastating the lives of individuals, families and communities. HIV/AIDS is a serious problem in our region and is on the rise in some countries in the Pacific. The consequences of the HIV/AIDS epidemic go beyond the loss of lives and the health care costs directly associated with the disease. In addition, it is an obstacle to development and has wide-ranging social and economic impacts. We in the Pacific, with a relatively poor economic base, will continue to suffer economically in the years ahead. We wish to acknowledge the new Global Fund to Fight AIDS, Tuberculosis and Malaria. It is an important expression of solidarity. But if it is to succeed, those with resources need to back their commitment with real money; not just on a one-off basis but regularly and reliably. We are proud to be recognized as the first multi-country proposal to be approved under the Global Fund mechanism in the second round. This multi-country project signifies the uniqueness of the Pacific in terms of collaboration and cooperation, despite the geographical spread of island countries in the vast Pacific Ocean and the existence of diverse cultures and languages. We need to react to this with common objectives; to implement the relevant prevention and care activities in partnership to roll back this pandemic. We acknowledge the assistance that the staff in the WHO Regional Office for the Western Pacific extended to us in developing this regional proposal.

The population dynamics of the Pacific island nations are complex and include varying population sizes and densities, high fertility rates leading to an increase in the proportion of the population aged less than 15 years, and rising levels of internal migration and urbanization. Coupled with these factors, the significant amount of coastal trade in the region poses a major threat and the potential for a rapid spread of HIV/AIDS across borders. The leaders of the Pacific Islands Forum recognize the significant impact of these factors and of this disease in undermining developmental gains in the region, as life expectancy and child survival rates decline.

We wish to alert you to the current practice of the WHO system whereby the prevalence rate of the disease is not considered as important as the absolute number of cases when it comes to resource distribution. We should pay attention to this before we make a mistake that may not be affordable in the future. Although our numbers of HIV/AIDS cases are small in comparison with Africa and other parts of the world in real terms, the loss of a few lives has an enormous impact on our human resource base. We respectfully request WHO to consider the peoples of the Pacific as part of the "3 by 5" initiative and stress again the importance of taking immediate action now within the Pacific region.

We should address the needs of people living with HIV/AIDS for access to treatment (including clinical management of their illness), nursing care, counselling, and social and psychological support. Evidence shows that it is possible to deliver care and treatment to people living with AIDS in resource-poor settings. Recent advances in research, simplified treatment schemes and drastic price reductions now make it possible to envisage that millions of poor people who need antiretroviral therapies could indeed obtain them and thus have a chance of living a full life. On that note, we ask WHO, in collaboration with other partners, to continue to negotiate with the pharmaceutical industry and to make sure HIV drugs are more affordable. Extending access to these drugs is not just through prices but also through reliable supply systems, laboratory back-up, patient supervision, monitoring of drug resistance and setting of clear priorities and ethical policies.

Our Pacific island nations carry the burden of some of the highest rates of noncommunicable diseases in the world. Diabetes mellitus, hypertension and ischaemic heart disease are among the many noncommunicable diseases affecting the islands as a result of the fast-changing lifestyles of our people. In this regard, Pacific island countries welcome the WHO STEPwise approach to surveillance of noncommunicable disease risk factors. The extension of this approach to all Pacific island countries will greatly improve the statistics we have today. The Pacific island nations also recognize the important work of WHO in its Framework Convention on Tobacco Control. The Pacific island countries were among the first to ratify the Convention and the majority are signatories to it.

Our Governments in the Pacific region will continue to help each other to make a difference through coordinated preventive and care activities involving health professionals, the many stakeholders and civil society. We Pacific island nations extend our strong support in leading this Organization to greater things to come.

The PRESIDENT:

Thank you very much, honourable delegate of Tuvalu. Your concerns regarding the prevalence rate shall be taken into consideration. Also the Pacific area should be considered for the "3 by 5" initiative. WHO will take note of your concern that HIV/AIDS drugs should be affordable. I congratulate the Pacific island countries for being among the first to sign the WHO Framework Convention on Tobacco Control.

Mrs GIJASOVA (Uzbekistan):
Г-жа ГИЯСОВА (УЗБЕКИСТАН):

Уважаемые дамы и господа, уважаемый г-н Председатель.

Разрешите, г-н Председатель, поздравить Вас с назначением на пост Председателя Пятьдесят седьмой Ассамблеи. Республика Узбекистан приветствует Всемирную организацию здравоохранения за проведение сегодняшнего пленарного заседания, посвященного обсуждению одной из глобальных проблем этого тысячелетия – предотвращению и лечению ВИЧ/СПИДа, особенно в странах с развивающейся экономикой.

Сегодня ясно, что не существует единой простой формулы, которую можно применять без учета специфических особенностей страны. Проводимые сегодня национальные мероприятия, учитывающие данный аспект, оказываются наиболее эффективными: они воздействуют на изменение конкретных ситуаций, сложившихся в отдельной стране.

Эпидемиологическая ситуация по ВИЧ, сложившаяся за последние два года в нашей Республике, заставила нас всех взглянуть на проблему по-новому. Перед правительством и общественностью встал вопрос о неотложных, скоординированных и комплексных мерах по борьбе с ВИЧ/СПИДом. Узбекистан стоит на пороге концентрированной стадии эпидемии ВИЧ с преобладанием этой инфекции среди потребителей инъекционных наркотиков.

Общее количество официально зарегистрированных случаев ВИЧ в Узбекистане на 1 января 2004 г. составило чуть более 3,5 тысяч человек. Потребители инъекционных наркотиков существенно преобладают среди официально зарегистрированных ВИЧ инфицированных лиц, их доля составляет около 65%. Однако уже имеет место распространение ВИЧ-инфекции и половым путем. Многочисленные экспертные оценки свидетельствуют о том, что реальная цифра ВИЧ-инфицированных в Узбекистане может быть значительно выше, чем официально зарегистрированная. Это свидетельствует о том, что количество людей, нуждающихся в высокоактивной антиретровирусной терапии, будет только расти.

В ответ на сложившуюся ситуацию в стране разработана многосекторальная стратегия профилактики и борьбы с ВИЧ/СПИДом. Данное мероприятие предусматривает адаптацию и оказание поддержки людям, живущим с ВИЧ/СПИДом, включая высокоактивную антиретровирусную терапию, особенно для детей, подростков, взрослых пациентов, а также лечение оппортунистических инфекций, профилактику ВИЧ, передаваемого от матери ребенку. В Республике созданы условия для анонимного конфиденциального обследования до и после тестового консультирования на ВИЧ в отдельных анонимных кабинетах и кабинетах доверия. Республиканская правительственная комиссия утвердила в мае 2003 г. Стратегическую программу противодействия распространению эпидемии ВИЧ/СПИДа в Республике Узбекистан.

Как известно, в конце 2003 г. было принято решение Глобального фонда для борьбы против ВИЧ/СПИДа, туберкулеза и малярии о выделении Узбекистану средств в размере 24,5 млн. долл. США сроком на пять лет на профилактику и лечение ВИЧ/СПИДа. Одна из главных целей Глобального фонда - обеспечить ВИЧ-инфицированных антиретровирусной терапией. В ближайшее время антиретровирусная терапия станет неотъемлемой частью комплексной медицинской помощи людям, живущим с ВИЧ/СПИДом.

В соответствии с вышесказанным, Республика Узбекистан будет участвовать в выполнении стратегии Всемирной организации здравоохранения "3 к 5".

Пользуясь случаем, хочу выразить благодарность и признательность всем международным, правительственным и неправительственным организациям, участвующим в деле борьбы со СПИДом.

Международный опыт и международный обмен опытом способствуют улучшению работы по профилактике и борьбе с распространением ВИЧ/СПИДа.

Благодарю за внимание.

The PRESIDENT:

Thank you, honourable delegate of Uzbekistan. I compliment you for showing care for HIV patients.

Dr CHUA SOI LEK (Malaysia):

The twenty-first century has been a very challenging one for many countries. But of utmost importance are the challenges posed by infectious diseases as exemplified by the HIV/AIDS pandemic, the outbreak of severe acute respiratory syndrome (SARS) last year and, more recently, avian influenza. The economic fallout, especially for tourism, travel and trade, has affected many

countries, particularly in the Asia-Pacific region. Much has been said about HIV/AIDS at this Fifty-seventh World Health Assembly in the past two days. It has been made the round table topic this year. Malaysia is committed to the global initiative to fight HIV/AIDS and also the "3 by 5" initiative of WHO. We will work to ensure easy accessibility to drug treatment for HIV/AIDS patients by reducing the cost of antiretroviral drugs.

The world today has no real boundaries. Just as computer viruses can spread through the Internet, so too can viruses of infectious diseases spread across nations, especially with the rapid increase in travel and trade. The advent of budget airlines has further facilitated access to air travel. The emergence of health problems that transcend national boundaries has become a major challenge to the many countries, especially in the Asia-Pacific region, where the tourism industry plays a big role in bringing in foreign exchange. Thus, the strengthening of collaboration among countries, especially in the surveillance, prevention and control of communicable disease, has become a priority in order to address the challenges posed by emerging and resurgent infection. The SARS outbreak last year elicited an unprecedented level of regional and global cooperation among countries. As you will recall, there were several regional meetings during the SARS outbreak to deal with the problem within the region covered by the Association of South-East Asian Nations (ASEAN), and several initiatives took place in the areas of epidemiological capability and capacity-building, laboratory surveillance and disease surveillance networking. Malaysia hosted the 7th ASEAN and 1st ASEAN+3 Health Ministers' Meetings in April 2004 with the theme "Health Without Frontiers", where the 10 ASEAN health ministers and the health ministers of China, Japan and the Republic of Korea agreed on the continuing need for regional collaboration, including the need to strengthen infrastructure and to support regional capacity in responding to disease outbreaks including HIV/AIDS. We would like to see the support of WHO in this effort to strengthen cooperation and collaboration in the ASEAN+3 grouping, as some ASEAN members are in the WHO South-East Asia Region, while others are in the WHO Western Pacific Region. WHO can provide the technical support and expertise that are necessary to realize these objectives. WHO can also play a role in fostering closer collaboration between the Regions so as to prevent duplication of effort. Within the Regions there are many other forums that can be used to promote cooperation in disease prevention and control, be it a recent outbreak or an already-established pandemic such as HIV/AIDS. In our efforts to eradicate diseases such as poliomyelitis, such regional collaboration can also be utilized. An example is Malaysia's advocacy in the eradication of poliomyelitis through the Organization of the Islamic Conference (OIC). Malaysia is fully committed to the global poliomyelitis eradication initiative of WHO. Leaders at the 10th Session of the Islamic Summit Conference which was held in Kuala Lumpur in October 2003, and member countries were urged to assist WHO in the final push to eradicate poliomyelitis and to finance the funding gap by the end of this year. To this effort Malaysia is pleased to contribute a small token sum of US$ 1 million. I know that this is a very small amount but I hope it is a good start. After all, it is said that a journey of a thousand miles begins with a first step.

The stakes are high and the challenges are many, but I am sure that with the strengthening of cooperation and collaboration among countries and among regions and with the leadership and support of WHO, we can make this world a healthier and a happier place to live in.

The PRESIDENT:

Thank you, honourable delegate of Malaysia. I thank you for your comments on surveillance and global cooperation which are critical in a globalized world. WHO will take note of your suggestions and commends you for your positive work for the eradication of poliomyelitis. We are very, very thankful for your generous offer in financial terms.

Dr DAVIDYAN (Armenia):
Д-р ДАВИДЯН (АРМЕНИЯ):

Уважаемый г-н Председатель Всемирной ассамблеи здравоохранения, Генеральный директор ВОЗ, министры и главы делегаций, коллеги.

Прежде всего, г-н Председатель, позвольте поздравить Вас с избранием на высокий пост и пожелать Вам успеха в столь ответственной роли.

Делегация Армении высоко ценит Ваши усилия и умелое руководство работой Всемирной ассамблеи при столь важной поддержке со стороны ваших заместителей и других должностных лиц Ассамблеи и, конечно же, г-на Генерального директора и Секретариата ВОЗ.

Правительство Армении придает большое значение охране здоровья нации и укреплению сектора здравоохранения. Благодаря устойчивому экономическому росту за последние годы страна добилась постоянно возрастающего финансирования здравоохранения. А принятый несколько месяцев назад государственный бюджет на 2004 г. можно охарактеризовать истинно "поворотным" в смысле его ярко выраженной социальной направленности.

Другим важным результатом экономического роста явилось зарегистрированное впервые в прошлом году заметное снижение уровня бедности, что, несомненно, привнесет значительный вклад в укрепление здоровья нации и эффективность политики здравоохранения. Наконец, важными являются устойчивые и положительные сдвиги по ряду показателей, такие как заметное снижение младенческой и материнской смертности, сравнительно высокая, по сравнению со странами СНГ, средняя продолжительность жизни.

В 2003 г. Армения официально была зарегистрирована как страна, свободная от полиомиелита. Есть все предпосылки для достижения в течение ближайших двух лет статуса страны, свободной также от малярии. В то же время страна все еще подвержена возрастающей угрозе хронических заболеваний с учетом их доли в общих показателях заболеваемости и смертности. Пользуясь случаем, я хотел бы выразить полную поддержку вынесенной на обсуждение настоящей Ассамблеи Глобальной стратегии по питанию, физической активности и здоровью, которая наряду с Рамочной конвенцией по борьбе против табака способна внести важный вклад в борьбу против широкого спектра сердечно-сосудистых, онкологических и других неинфекционных заболеваний.

Уважаемый Председатель.

Армения не осталась в стороне от воздействия эпидемии ВИЧ/СПИДа. На сегодняшний день картина, конечно же, не катастрофическая, как во многих других странах. Всего зарегистрированы 272 ВИЧ-инфицированных случая, из них 50 - больных СПИДом. Однако мы понимаем, что число незарегистрированных случаев может быть весьма значительным (по расчетным данным до 3000), и к тому же взрыв эпидемии в Восточной Европе является более чем настораживающим. Осознавая важность проблемы, правительство Армении приняло и внедряет национальную программу по профилактике ВИЧ/СПИДа.

Пользуясь этой высокой трибуной, хотел бы выразить глубокую благодарность Глобальному фонду для борьбы против СПИДа, туберкулеза и малярии за выделение Армении гранта в размере более 7 млн. долл. США для противодействия этой страшной эпидемии.

Хотелось бы также отметить, что в Армении вот уже более семи лет группа ученых работает над всесторонним изучением созданного ими препарата "Арменикум", который проявляет выраженный терапевтический эффект на разных стадиях ВИЧ/СПИДа. Препарат после разностороннего предклинического исследования был апробирован на более чем 600 больных СПИДом из 40 стран. И при этом были получены весьма положительные результаты. Препарат резко улучшает качество жизни больного и, на наш взгляд, может сыграть важную роль в арсенале современных методов лечения ВИЧ/СПИДа.

Правительство Армении выражает полную поддержку новой глобальной инициативе ВОЗ "3 к 5" и готово к всестороннему международному сотрудничеству для ее успешной реализации.

Г-н Председатель.

Армения высоко оценивает авторитет и роль ВОЗ в укреплении здоровья и здравоохранения во всем мире. Мы высоко оцениваем также достигнутый за последние несколько лет уровень сотрудничества с ВОЗ, и при этом хотелось бы особо отметить плодотворное сотрудничество с Европейским региональным бюро ВОЗ.

Позвольте, г-н Председатель и Генеральный директор, заверить вас в приверженности Армении укреплению сотрудничества с ВОЗ на долгосрочной основе и еще раз пожелать успеха в работе Всемирной ассамблеи.

Спасибо.

Mme ESCHEIKH (Tunisie):

السيدة نزيهة الشيخ (تونس):

بسم الله الرحمن الرحيم،

السيد الرئيس، حضرات السادة والسيدات المندوبين الموقرين، حضرات السيدات والسادة، يسعدني، في مستهل كلمتي هذه، أن أعرب لرئيس جمعية الصحة العالمية السابعة والخمسين، عن أحر التهاني لانتخابه، متمنية له كامل النجاح والتوفيق في إدارة أعمالها وأن أهنئ كذلك السادة نواب الرئيس وجميع الذين حظوا بثقة جمعيتنا.

كما يطيب لي أن أعبر عن مشاعر امتنان الجمهورية التونسية للسيد المدير العام ولكافة معاونيه الساهرين على شؤون منظمتنا، وأن أنوه بالجهود السخية التي يبذلها في سبيل إنجاح برامجها. الشكر موصول كذلك إلى السيد مدير المكتب الإقليمي لشرق المتوسط على ما يقدمه من دعم متواصل لبرامج الصحة في تونس وفي الإقليم عموماً.

السيد الرئيس، إن اهتمام المنظمة العالمية بالمشاغل الصحية العالمية المعهودة منها والمستجدة، يعكس مدى حرصها على مواجهة كل ما يهدد صحة الإنسانية سواء بما توفره من دعم مادي أو ما تسخره من سند تقني ساهم، ولايزال، في مساعدة الكثير من البلدان على تقييم وتأهيل نظمها الصحية ووضع الخطط والاستراتيجية الملائمة الكفيلة بالنهوض بصحة مواطنينا. إن التغيرات التي يشهدها العالم سواء أكانت ناتجة عن حروب أم كوارث طبيعية وما يطرأ من حين لآخر من آفات وأمراض لم تكن في الحسبان حدا بالمنظمة إلى التطرق إلى مختلف هذه المعضلات والتأكيد على أهمية مكافحة الأمراض المستجدة والمتجددة وجعلها ضمن أولويات برامجها. كما أن العولمة الاقتصادية وما تقتضيه من انفتاح على الأسواق وتنقل سريع للأشخاص والبضائع بشتى أنواعها تحتم على المنظومة الدولية، وبإشراف منظمة الصحة العالمية، التنسيق والتعاون لمجابهة ما يمكن أن ينجم عن ذلك من أخطار والاستعداد لها لأنه لا يمكن لأي بلد مهما كانت إمكانياته أن يكون في مأمن من التغيرات الوبائية وما تسببه من مخلفات وتهديدات متفاوتة الخطورة وهو ما يدعونا جميعاً إلى دعم اليقظة والاستمرار في الرصد الوبائي للأمراض السارية ويدفع الدول المصنعة إلى مساعدة الدول النامية لتعزيز نظمها الصحية ووضع الخطط الكفيلة بمجابهة الأمراض والآفات باعتبار أن ذلك من شأنه أن ينعكس بالإيجاب على الجميع. ويكفي هنا أن نذكر بآفة الالتهاب الرئوي الحاد الوخيم الذي تجاوز تهديده أغلب الحدود فلم يفرق بين البلدان النامية والبلدان المصنعة.

كما أن تمشي المنظمة في معالجة جميع المشكلات الصحية الحاصلة أو لاستباق حدوث العديد منها سواء أكان الأمر يتعلق بكافة بلدان العالم أم ببعض المناطق دون سواها يمثل خير دليل على نبل مساعي المنظمة ومراميها ويدفع الجميع إلى مؤازرة جهودها الخيرة والمساهمة في تحقيق الأهداف المنشودة باعتبارها تعود بالخير على الإنسانية قاطبة.

حضرات السادة والسيدات، إن المواضيع المختلفة المطروحة للنقاش خلال هذا الاجتماع تتسم كالعادة بالشمولية نظراً لإتيانها على مختلف المسائل التي تشغل الشعوب والحكومات. فالتطرق، على سبيل المثال، لموضوع الأسرة والصحة يعبر عن إيمان المنظمة، ومن ورائها مختلف الدول الأعضاء، بضرورة مزيد العناية لدعم وظائف الأسرة وتطوير قدراتها حتى تلعب دورها الرئيسي في النهوض بصحة أفرادها ودعم ما تبذله النظم الصحية من مجهودات. كما أن تجديد العناية بالصحة الإنجابية في مفهومها الشامل يبرز مدى الحرص على تحسين خدمات الصحة الإنجابية لما لها من دور في تحقيق الأهداف الإنمائية للألفية باعتبارها تعنى بالفرد والأسرة وتسعى بتكريس العدالة الاجتماعية بتوفير خدمات جيدة للجميع بصفة عامة وللفئات الضعيفة بصفة خاصة وأخص بذلك المرأة والمراهقين والشباب. كما أن التأكيد على تعزيز أنماط الحياة الصحية والتصدي لعوامل الاختطار المتسببة فيها يبين الأهمية التي تحتلها مجابهة الأمراض غير السارية

ويعكس مدى سداد توجهات المنظمة واهتمامها بالمشاكل الصحية التي أفرزتها التغيرات الوبائية والديموغرافية والتي أصبحت تتصدر أسباب المراضة والوفيات في الكثير من البلدان. ومن منطلق حرص القيادة السياسية بتونس على النهوض بالموارد البشرية وتحقيق الرفاه للمواطن، تسعى المنظومة الصحية الوطنية إلى وضع استراتيجيات وأساليب لتعزيز الصحة تساهم في تخطيطها وتنفيذها وتقييمها، بالإضافة إلى الهياكل الحكومية، مختلف الجمعيات والمنظمات غير الحكومية ويكون للفرد فيها دور رئيسي من خلال تبنيه لسلوكيات صحية سليمة باعتباره الغاية والوسيلة في آن واحد.

سيدي الرئيس، إن تخصيص الموائد المستديرة لهذه الدورة للأيدز والعدوى بفيروسه يمثل إنذاراً متجدداً للتصدي لمخاطر هذه الآفة وآثارها الكاسحة ولاسيما على البلدان النامية التي تستفحل فيها العدوى ودعوة ملحة للحكومات والهيئات الدولية إلى مزيد التعاون والتنسيق للحد من انعكاسات هذا المرض هذه الانعكاسات الصحية والاقتصادية.

وإننا في تونس، وبالرغم من الاستقرار النسبي الملحوظ في المؤشرات الوبائية بخصوص الأيدز، نحرص على إيلاء هذا الموضوع مكانة هامة في سلم أولويات سياستنا الصحية والإسهام في المجهودات التي تبذلها المجموعة الدولية لمحاربة هذه الآفة. لقد عملنا، منذ تسجيل الحالات الأولى من العدوى بفيروس الأيدز، على تركيز برنامج وطني لمكافحة هذا المرض وعلى بعث لجنة وطنية متعددة الأطراف تساهم في تخطيط وتنفيذ وتقييم أنشطة المكافحة مع استغلال مختلف قنوات الاتصال. ومن المكاسب المسجلة في هذا المجال ضمان مأمونية نقل الدم ومجانية الكشف المخبري والإحاطة بالمصابين بالعدوى بما في ذلك توفير الميزانية اللازمة لتأمين العلاج الثلاثي المجاني لكل مستحقيه والرعاية الاجتماعية وكذلك الرعاية النفسية للمصابين مع محاربة الإقصاء والتمييز. كما أننا لم نتوان في القيام بتقييم نظام الترصد المتبع في بلادنا بهدف الوقوف على مدى نجاعته وقد أثبت الخبراء الدوليون الذين قاموا بهذه المهمة استجابة هذا النظام للمواصفات باعتباره يعكس حقيقة الوضع الوبائي المسجل بتونس وسنعمل على تدعيمه بإقامة مراكز مجانية للتقصي المصلي الطوعي والخفي الاسم لمنح فرص إضافية للمجموعات ذات الاختطار الشديد لمساعدتهم على الحصول على الرعاية والعلاج والتوعية والتحسيس.

وانتهز هذه الفرصة لأجدد مرة أخرى التزام تونس بتنفيذ إعلان الأمم المتحدة المتعلق بالألفية وإعلان الالتزام المتعلق بالأيدز والعدوى بفيروسه ودعمنا اللامحدود لمجهودات المنظمة وبرنامج الأمم المتحدة المشترك لمكافحة الأيدز لبلوغ الهدف المتمثل في علاج ثلاثة ملايين نسمة قبل نهاية سنة ٢٠٠٥ والحد من هذه المشكلة الصحية العالمية.

سيدي الرئيس، لا يفوتني، في خاتمة كلمتي، أن ألفت نظر الحضور الكريم إلى ما تتعرض له بعض الشعوب من انتهاكات ومآس وكوارث صحية يذهب ضحيتها عدد كبير من المدنيين الأبرياء وعلينا جميعاً أن نعمل من أجل التخفيف من معاناتهم وأخص بالذكر الفلسطينيين والعراقيين. وفقنا الله جميعاً لما فيه خير صحة البشرية، وشكراً لكم عن حسن الانتباه.

والسلام عليكم ورحمة الله وبركاته.

The PRESIDENT:

Thank you, honourable delegate of Tunisia. I want to thank you for your emphasis on peace, and also for saying that the safeguarding of civilians is extremely important. Surveillance and assistance to poor countries, and the emphasis on family health are noted, as the family is the nucleus of society, especially the mother.

Dr MASLOWSKI (Poland):

I take the opportunity and privilege on behalf of my delegation to acknowledge the inspiring role of the World Health Organization in stimulating and guiding our national health programmes and

actions. The WHO guidelines elaborated out of worldwide experience are highly prized in my country by all responsible for health; the management and the health delivery sectors. This Fifty-seventh World Health Assembly is a particular opportunity to share our national experience and exchange views on specific health problems relevant to our current health situation. Health development trends in their international context are reflected in the national health policy.

This year is marked for us in Poland with particular implications. On 1 May 2004, Poland became a member of the European Union. This new political and socioeconomic reality creates a new milieu and requirements for Polish health strategies. In this new circumstance, intercountry cooperation is an essential prerequisite for the efficiency, quality and flexibility of the health care system. This adds a new dimension to the health system and, together with other necessary health reforms, is the major political concern of my Government.

In taking the opportunity of addressing this Health Assembly, the most distinguished among worldwide health authorities, I would like to mention that we in Poland are currently working out a new concept of the national health strategy, rationally based on economic principles, to meet the essential health requirements of the population and to ensure health safety for both the community and individuals. Health has always been, and in particular is now, one of the most sensitive social issues. Thus, the entire concept of the health system is under scrutiny and public attention. New health legislative initiatives are in preparation. The specific health problem we are facing now is to ensure that all patients have equitable and unobstructed access to health services and – to that end – to overcome obvious financial constraints. Our health care reform is mainly oriented towards optimization of financing mechanisms for health services, rationalization of the pharmaceutical market and rearrangement of the hospital network – making the entire system patient-friendly, flexibly responsive and adjustable to community health needs. The strategy is aimed at presenting a comprehensive approach to all aspects of modern public health, compatible with up-to-date trends and health developments, and adopting inter alia the strategic principles of the WHO health-for-all policy. In the complex effort to update the community-oriented health policy, it is of utmost importance to assure the quality of health care at all levels of health infrastructure, and to maintain and monitor standards of care according to principles of evidence-based medicine. Patient safety is an integral part of quality assurance policy.

After an enriching and challenging public discussion, contesting the failures and omissions of the previous health care system, efforts are being directed towards adopting a programme that will be patient-friendly, less expensive and more efficient in health services delivery and accessibility. The programme emphasizes the responsibility of the state for the health of the population and, by doing so, exposes health as a prominent part of social policy as a whole. Close international cooperation in this area is a promising perspective.

Despite pressing economic challenges of how to afford the ever-growing costs of medical technology advances, we have raised the quality of health services appreciably and have noted considerable success in a number of priority clinical specialties. Satisfactory results are noted in health promotion: there is a noticeable decrease in smoking (from 31.5% to 27.6%). Life expectancy increased from 77.9 years (women) and 69.7 years (men) in 2000 to 78.4 years and 70.2 years respectively in 2001. The epidemiology of tuberculosis indicates a continual average improvement in morbidity and mortality rates. During the last three decades mortality from tuberculosis decreased by 83%. A parallel trend is noticed in infectious disease, where mortality fell by 50%. Vaccination rates for diphtheria, pertussis, measles, rubella, poliomyelitis and viral hepatitis reached 95-99%.

With regard to HIV/AIDS – the major agenda item for this Health Assembly – I would like to admit that recently, in comparison with some other countries, we have noticed in Poland a relatively stable epidemiological situation. It is worth mentioning that in recent years we have observed the changing profile of the HIV/AIDS epidemic, with an increased number of people infected owing to heterosexual contacts. Prevention, treatment and support are carried out in Poland by the National Programme for HIV Prevention and Care for People Living with HIV/AIDS, which is supported by the Government. Curbing the spread of HIV infection in Poland has been conducted through education, with particular emphasis on the education of youth; carrying out prevention actions among particularly vulnerable groups; regularly and permanently controlling the safety standards for blood and blood substitutes; and preventing diseases that favour HIV transmission. One of the core issues in

our common fight against HIV/AIDS is constant updating and introducing of international clinical guidelines for care for people living with HIV and AIDS. Preventing transmission of HIV and reducing the impact of HIV/AIDS in Poland fully ensures protection and promotion of human rights. Model testing centres have been operating in Poland since 1997. They offer anonymous, free-of-charge tests as well as pre- and post-test counselling. The National Programme ensures psychological and social support for people living with HIV/AIDS and their families. People living with HIV/AIDS in Poland have had access to specialized treatment since 1996. Patients who meet the clinical criteria receive free-of-charge antiretroviral treatment. However, HIV/AIDS treatment is still a challenge.

In conclusion, I would like from this rostrum to thank WHO headquarters, as well as the WHO Regional Office for Europe, for their support for my country in health development. We, for our part, declare our readiness to share with the Organization our experience and Polish professional expertise. We still think that intellectual and technological resources existing in the Member States could better serve mutual, intercountry interests, and could be used more widely.

The PRESIDENT:

Thank you, honourable delegate of Poland. We commend you on your HIV/AIDS programme and the blood safety procedures being followed in Poland.

Dr ABBAS (Iraq):

الدكتور عباس خضير (العراق):

بسم الله الرحمن الرحيم،

حضرة الأستاذ الفاضل محمد ناصر خان رئيس جمعية الصحة العالمية السابعة والخمسين، حضرات السادة وزراء الصحة الكرام، سيداتي وسادتي، إنه ليشرفني أن أقف أمامكم اليوم لأمثل وزارة الصحة العراقية في هذا المحفل الكريم. وإني، إذ أغبطكم على ما حققته بلدانكم في مجال الصحة، أتطلع لأن نفيد من خبراتكم في مجال الرعاية الصحية الآمنة التي طال انتظارها بسبب انعدام وجود نظام صحي مؤهل في ظل النظام السابق - إضافة إلى ما خلفته سنوات الحصار الطويل واستحقاقات الحروب القاسية، مما أدى إلى حرمان المواطن العراقي من حقه في الوصول إلى الخدمات الصحية المرجوة.

لقد كان العراق، قبيل الثمانينات، يتمتع بوفرة في الموارد المالية والبشرية مكنت القطاع الصحي في أن يكون رائداً في مجالات الخدمة الصحية سواء في التدريس أو التدريب أو الاشتراك في المؤتمرات العلمية العالمية وغيرها من مظاهر التقدم الصحي. لكن ثماني سنوات من الحرب مع الجارة إيران وثلاث عشرة سنة من العقوبات الاقتصادية بالإضافة إلى نزاعين مسلحين مع قوات التحالف كان لهما الأثر المدمر على الوضع الصحي في العراق مما أدى إلى ارتفاع معدلات وفيات الأمهات والأطفال الرضع والأطفال دون الخامسة إلى أضعاف ما كانت عليه، وازدادت معدلات انتشار الأمراض السارية وغير السارية، إضافة إلى تدني مستوى الخدمات الصحية إما لشحة الموارد أو بسبب هجرة الكفاءات الطبية أو كليهما.

إن رؤيتنا الشمولية لعراق حر وصحي تهدف إلى تمكين جميع الناس من الوصول إلى الخدمات الصحية بطريقة سهلة وغير مكلفة وسيكون توزيع الموارد اعتماداً على عدد المسجلين لتلقي الخدمة في المؤسسات الصحية. وهكذا، يتم لأول مرة إشراك المواطنين في عملية صنع القرار المتعلق بعافيتهم الصحية. كما تشدد هذه الرؤية الشمولية على ضرورة قيام مقدمي الخدمات الصحية الذين يختارهم الناس بتقديم حزمة متكاملة من الخدمات الصحية الأولية الجيدة تشمل العناية الوقائية، ورعاية الأمومة والطفولة - بما فيها خدمات الصحة الإنجابية والأدوية وغيرها من الخدمات الصحية الاجتماعية.

وتركز هذه الرؤية أيضاً على ربط نظام توفير الخدمات الصحية بالمجتمع، وقد تكون هناك أدوار هامة للمنظمات المجتمعية والمنظمات غير الحكومية في عملية تقويم الأطباء والممرضات في مجال تعزيز الصحة ومجال التعليم الذي يدخل في إطاره اختيار الأدوية المناسبة. لكن الأهم في كل هذا هو ما نعمل عليه الآن للتحول من نظام صحي مركزي إلى نظام لا مركزي يوفر على المواطن في كل محافظة سلبيات البيروقراطية وتفادي الروتين التقليدي.

أيها الأخوات والأخوة الكرام، بالرغم من الظروف الاستثنائية التي يمر بها العراق تمكنت وزارة الصحة من الاستمرار في تقديم الخدمات في كافة المؤسسات الصحية مجاناً والاستجابة للإصابات الجماعية التي تحدث نتيجة الهجمات الإرهابية والسيطرة على التفشيات الوبائية والاستمرار في تنفيذ برنامج مأمونية الدم. ولعل أبرز نجاح في مجال الصحة العامة هو تطعيم ٥,٥ مليون طفل عراقي في الفئة العمرية (٦-١٢) سنة بلقاح الحصبة المختلط خلال شهر آذار/ مارس من هذا العام مع تحقيق نسبة تغطية أكثر من ٩٠٪ حيث شارك في الحملة أكثر من خمسة آلاف فريق تطعيمي. أما في مجال مكافحة مرض الأيدز والعدوى بفيروسه فإن العراق مستمر في تنفيذ برنامج الرصد الوبائي للمرض في، مجاميع الاختطار وإعادة الاتصال مع المرضى المصابين قبل الحرب كما تم تشكيل لجنة عليا لمكافحة الأيدز برئاسة وزارة الصحة وعضوية الوزارات والمنظمات المعنية لتحديد السياسة الوقائية التي تحول دون تفشي المرض. وقد اعتمد البرنامج في فعالياته أيضاً استراتيجيات الحد من انتقال العدوى عن طريق الاتصال الجنسي والدم ومشتقاته ومن الأم المصابة إلى الطفل في فترة ما حول الولادة. كما تضمن تقديم الرعاية الصحية والاجتماعية للمرضى والتي شملت تقديم مساعدات مالية شهرية والمعالجة والفحوص الدورية المجانية للمصابين وتوفير سكن مناسب مع مستلزمات المعيشة اليومية لمن لا يتوفر لهم سكن.

وعلى الرغم من أن العراق يقع ضمن البلدان ذات التوطن المنخفض للمرض إلا أن هناك مخاوف من زيادة عدد الإصابات نتيجة الظروف التي يمر بها حالياً بعد الحرب وعودة أعداد كبيرة من المهجرين إلى الوطن من مناطق ذات توطن مختلف وحركة السكان داخل القطر وتفشي البطالة والفقر ونقص أدوية الأيدز. وزيادة عدد إصابات الأمراض المنقولة جنسياً قد تؤدي بمجموعها إلى تفشيات غير متوقعة ومن هذا الجانب فان العراق يتطلع إلى المزيد من الدعم المادي والتقني في هذا المجال. أما في مجال السلامة على الطرق فإن الإصابات المرورية في العراق تشكل واحدة من أهم أسباب الوفيات والعجز كما هو الشأن في باقي دول منطقة الشرق الأوسط وكما يتبين ذلك من جدول مقارنة لعدد الوفيات في بعض دول العالم والعراق.

إن الأهداف الرئيسة المباشرة للوزارة تتلخص في تجديد وترميم مرافق الرعاية الصحية الأولية والمستشفيات، وإصلاح أو استبدال المعدات وتأمين تجهيز للمواد الصيدلانية وبناء القدرات البشرية. وختاماً، إننا في العراق، كما في كثير من البلدان، نتطلع لأن نجد لأنفسنا مكاناً بارزاً في تأمين الأفضل لمواطنينا وأن لدينا كل الثقة والأمل بأنكم لن تبخلوا علينا بخبرتكم وإسهامكم في وصولنا إلى أمننا الصحي وسلامة رعايتنا الصحية.

والسلام عليكم ورحمة الله وبركاته.

The PRESIDENT:

Thank you, honourable delegate of Iraq. As for your statement, Iraq was a pioneer for health care before the war. Your comments in reference to the victims of conflict, especially infants, children, women and civilian population, are noted. Your desire for peace and to build your health system again is appreciated by WHO.

Dr KARAM (Lebanon):

A question comes to mind: since last May's Health Assembly, has the world we are living in been a better one? Human souls have been lost at a fast pace to human conflicts, to terror and atrocities, to famine and disease. Have we as leaders in our societies instilled in our citizens consideration for others, no matter what their colour, race or creed may be? Have we promoted in our societies respect for others, different ideas and opinions and respect for such differences? We, and the World Health Organization, should strive together to make health a universal right, globally applied in a fair and equitable manner. We should support WHO as the advocate for its promotion worldwide, urging all concerned to establish policies and action plans leading to available and accessible health care. In this respect, WHO must cooperate with all Member States, regardless of their political and economic systems, to protect the health of their people along with fundamental freedoms. This cannot

be done without proper consideration of national and regional particularities and the different historic, cultural, religious and ethnic backgrounds.

Health cannot be promoted and maintained while its adversaries – wars, dissension and poverty – thrive. Wars should stop and peace prevail; conflicts should be resolved and justice acclaimed; poverty should fade and human dignity be hailed. In peace, through basic and equal human rights, we can effectively fight poverty and combat disease, we can rightfully be the disciples of health.

Bayonets, like dictatorships, cannot establish democracy, still less protect it. Likewise, germs cannot define health, still less negate it. An Arabic proverb says, "Health is a crown on the head of the healthy". No man or woman should be denied the dream of being a king or a queen, and no crown could ever surmount a bowed head. Let us keep our heads up for a better, healthier and more humane world, a world that our children rightfully deserve.

The PRESIDENT:

Thank you, honourable delegate of Lebanon. Your desire for a better world, respect for others irrespective of their colour or creed, and the emphasis on peace and justice are appreciated and noted.

El Dr. BALAGUER (Cuba):

Señor Presidente, distinguidos delegados, observadores y demás participantes en esta 57ª Asamblea Mundial de la Salud: Vivimos una época caracterizada por la aparición de enfermedades emergentes y reemergentes. Todo ello inmerso en un panorama mundial de mayor pobreza, hambre, de millones de personas sin asistencia médica básica, desigualdad social, brecha creciente entre países pobres y ricos y afectaciones incalculables a sus economías, sociedades y medio ambiente como consecuencia de las guerras. Los países pobres son los más afectados.

Señor Presidente: en el mundo viven 40 millones de personas con el VIH/SIDA sin acceso a un tratamiento eficaz. La mayoría de ellas no sobrevivirá al próximo decenio. Hasta ahora la epidemia ha cobrado la vida de más de 20 millones de personas. De ellas sólo en el 2003 fallecieron tres millones. Existen cerca de 14 millones de niños huérfanos a consecuencia de esa enfermedad, la mayoría de ellos de África. Si no se detiene la tendencia creciente, se alcanzará la cifra de 25 millones de niños huérfanos en el año 2010. Lograr el objetivo de proporcionar tratamiento antirretroviral eficaz a no menos de tres millones de personas de países en desarrollo para el 2005, como está proponiendo la OMS, es una emergencia. En mi país contamos como estrategia clave para el enfrentamiento de la epidemia del SIDA de un programa de prevención y control que integra todos los componentes sugeridos por la OMS: vigilancia epidemiológica, prevención, atención y cuidados, diagnóstico e investigaciones, dentro del cual se garantiza al 100% de los enfermos de forma gratuita el tratamiento antirretroviral cuyos medicamentos son producidos nacionalmente.

Señor Presidente: el Gobierno de los Estados Unidos de América, en franco desafío al derecho internacional, acaba de aprobar el pasado 6 de mayo nuevas brutales medidas económicas y políticas que recrudecen aún más su agresividad y hostilidad contra Cuba. Dentro de las nuevas acciones se plantea que una vez derrocado el gobierno actual de Cuba se vacunarán a todos los niños menores de cinco años. Mueve a risa escuchar promesas futuras de vacunar a niños en un país donde la medicina preventiva y la vacunación alcanzan los más altos niveles del mundo y se proclama desde un país donde decenas de millones de hombres, mujeres y niños carecen de la asistencia médica y mueren más niños por cada mil nacidos vivos que en Cuba.

Tal vez se desconozca que en mi país se aplican 10 tipos de vacunas que protegen a nuestros niños contra 13 enfermedades, siendo la cobertura de la vacunación del 95%. Como resultado de esta estrategia, en los últimos 40 años se han logrado eliminar seis enfermedades: poliomielitis en el año 1962, difteria en 1979, sarampión en 1993, tos ferina en 1994, y rubéola y parotiditis en 1995, así como dos forma clínicas severas, la meningitis tuberculosa y el tétanos neonatal. Cuatro de estas enfermedades no han podido ser erradicadas en el territorio de los Estados Unidos.

Además, desde 1988 se vacuna contra la meningitis meningocócica tipo B, única en el mundo producida en Cuba, y la C, de producción nacional, a todos los menores de 30 años. Desde 1991, se

vacuna contra la hepatitis tipo B a todos los menores de 25 años y a los grupos de riesgo como enfermos de diabetes, a médicos y enfermeros de la familia, a trabajadores de bancos de sangre, a trabajadores de instituciones para enfermos mentales, reclusos y portadores y contactos de enfermedades de transmisión sexual, con una vacuna de producción nacional por métodos de ingeniería genética. Se vacuna también contra *Haemophilus influenzae* tipo B con una vacuna cubana producida por síntesis química, única en el mundo mediante esta tecnología.

Lo que trata realmente Estados Unidos es destruir esta obra que constituye para nosotros los cubanos un culto sagrado a los derechos del ser humano. Es significativo que los países más desarrollados del mundo, con un per cápita interno superior en 20 ó 40 veces superior al de Cuba, no hayan podido lograr aún tales resultados de vacunación en sus respectivas poblaciones.

Todo ese esfuerzo ha sido desarrollado por el pueblo cubano, a pesar del bloqueo económico, comercial y financiero que el Gobierno de los Estados Unidos de América impone a Cuba desde hace 45 años.

Señor Presidente: Cuba ha ofrecido ante Naciones Unidas y ante la Comunidad de Estados del Caribe su disposición de enviar médicos y otro personal de salud a África y el Caribe para la lucha contra el SIDA, así como la creación de facultades de medicina y de enfermería para darle sostenibilidad a la colaboración. Actualmente, más de 17 000 médicos cubanos y otro personal de salud brindan sus servicios en 65 países. Ya se han creado nueve facultades de medicina.

Por otro lado, en los últimos 40 años se graduaron en Cuba más de 40 000 jóvenes de más de 100 países del tercer mundo como profesionales universitarios y técnicos calificados sin costo alguno, 30 000 de ellos procedentes de África. Asimismo, a lo largo de ese tiempo, más de 70 000 médicos y trabajadores de la salud cubanos, que han salvado millones de vida, prestaron servicios voluntaria y gratuitamente en 94 países.

Ponemos a disposición de los Estados Miembros nuestra modesta experiencia en el campo de la salud y particularmente en la lucha contra el SIDA.

The PRESIDENT:

Thank you, honourable delegate of Cuba. Your figures on orphans in Africa due to HIV/AIDS – 14 million now and 20 million in the year 2010 – are alarming. That is why we all have to work together with WHO with commitment to fight this deadly epidemic that is eating our children and our women and our families.

La Sra. GUARDIÁN (Nicaragua):

Señor Presidente, distinguidos miembros de la Mesa, honorables miembros de esta Asamblea: Asegurar una mejor salud es un requisito para el desarrollo económico y la cohesión social. Hay un colega nuestro que dice y repite que la salud no lo es todo, pero sin salud no hay nada. Al iniciar el siglo XXI podemos afirmar que la situación de salud de los nicaragüenses ha mejorado. Los principales indicadores nacionales muestran importantes avances en la mortalidad infantil y en los menores de cinco años; el incremento de la esperanza de vida al nacer; de la cobertura de inmunización y del acceso a servicios básicos tales como agua potable y disposición de excretas. Sin embargo persisten desigualdades injustas y evitables y hay mucho por hacer.

Aún se reportan altas tasas de mortalidad infantil, perinatal y materna. Se ha reportado la disminución de la mortalidad infantil en los quintiles con mayores recursos, no siendo así en los quintiles de menores recursos; coberturas de inmunizaciones no útiles en municipios de difícil acceso a los servicios de salud y con altos índices de pobreza. El 40% de la población todavía no tiene acceso al agua potable, ni a una adecuada disposición de excretas, y el 35% del personal de salud se concentra en las áreas más desarrolladas del país Persisten las enfermedades transmitidas por vectores y el aumento de la morbilidad por afecciones crónicas. A esto se suma el incremento de los casos de VIH/SIDA, de lesiones por violencia y accidentes de tránsito.

Se ha enfatizado en reducir la mortalidad más que en la prevención de la enfermedad y la promoción de la salud. Reconocemos que la promoción de la salud es esencial para prevenir más del 60% de las enfermedades que aquejan a nuestra población. Es por eso que el Ministro de Salud ha

declarado este año, como el «Año de la prevención con visión de Nación». Y con ello hemos elaborado una estrategia de comunicación de salud y acción comunitaria de todo el sector de salud que trasciende al Ministerio de Salud.

¿En qué hemos avanzado en el 2003 y el 2004? El Gobierno de Nicaragua ha elaborado el Plan Nacional de Desarrollo, donde se establecen los lineamientos estratégicos básicos para el sector salud, para el cual realizó una revisión de los Objetivos, Metas e Indicadores del Milenio adaptándolas al país.

Somos conscientes de que para alcanzar niveles de salud aceptables y responder a los retos con que nos enfrentamos, debemos transformar nuestro sistema de salud en uno más equitativo y sostenible. Para ello nos hemos enfrascado en diferentes procesos que parten del principio de que el ser humano debe constituir el centro de nuestro quehacer. Por ello, la calidad y calidez de la atención a los servicios se convierten en fundamento de la nueva política de salud y del Plan Nacional de Salud con vigencia hasta el 2015, coincidiendo con la fecha establecida para alcanzar las Metas del Milenio.

Otros lineamientos generales de esta política son la ampliación de la cobertura de los servicios, promover la gobernabilidad del sector salud, el ordenamiento de la red de servicios de salud, fortalecer la capacidad gerencial y el desarrollo de los recursos humanos, y la implementación de estrategias innovadoras en salud en las Regiones Autónomas de la Costa Atlántica, respetando las características de desarrollo político, demográfico, étnico y cultural de sus poblaciones.

Hemos finalizado la definición de un modelo de atención integral de salud que pretende disminuir la mortalidad y la discapacidad prematuras, la morbilidad evitable. Hemos hecho un esfuerzo en trabajar hacia un mejor acceso a los medicamentos esenciales, y aquí nos han acompañado la OMS y la OPS.

A fin de alcanzar los objetivos nacionales y compromisos mundiales, se requiere una cooperación sin precedentes entre los gobiernos, organismos multilaterales y bilaterales, organismos no gubernamentales, comunidades, el sector privado para actuar con sentido de urgencia en un enfoque sectorial. Esto permitirá una mejor planificación de los recursos disponibles y enfocarlos más eficaz y eficientemente en la población más vulnerable de nuestro país. Y de esta manera daríamos pasos significativos hacia la equidad.

¿Cuál es nuestro camino al futuro? Estamos comprometidos como Ministerio de Salud y como país en entregar a los niños y niñas de esta parte de la Región de las Américas, un país con cielo, aire, agua limpios, con árboles, con entornos saludables, donde cada comunidad, cada familia sepa cómo asegurar el desarrollo y crecimiento saludable de sus hijos e hijas, en armonía con la naturaleza y sin violencia.

The PRESIDENT:

Thank you, honourable delegate of Nicaragua. I compliment you for declaring this year in Nicaragua the national year of disease prevention.

Mr KONCHELLA (Kenya):

On behalf of the Kenyan delegation, may I take this opportunity to express our gratitude to the Director-General for his continued support to our country. Kenya has made progress in many aspects of health over the past year, while also consolidating the gains from previous years. Nevertheless, we have also experienced new challenges that call for new solutions which we are seeking through our own initiatives and by building partnerships with national and international agencies. In line with the road safety theme for this year's World Health Day, I am pleased to report that the Kenyan Government, in collaboration with many stakeholders, has adopted a multisectoral approach to the prevention of road traffic injuries by formulating a new transport policy.

May I also express our gratitude for the honour bestowed on our country which hosted the official global launch of the "3 by 5" strategy on HIV/AIDS by WHO and UNAIDS in Nairobi late last year. HIV/AIDS remains the most serious health and development problem in Kenya. The Government of Kenya continues to view HIV/AIDS control as a priority activity, and has increased financial commitment to preventing HIV transmission, and caring for and supporting those already

infected. As a result of concerted efforts by Kenyans and their Government, together with development partners, the HIV prevalence rate among mothers attending antenatal clinics has dropped from 13% in the year 2000 to 9.4% in 2003, while that in the general population is now estimated at 7%. On prevention strategies, the demand for voluntary counselling and testing has greatly exceeded expectations, far outstripping the service delivery capacity. There is already a behaviour change trend with a notable decline in sexually transmitted infections, a reduction in the number of sexual partners, and increased consistency of condom use. We currently have 11 000 patients on antiretroviral therapy. This is far short of our goal of reaching 140 000 patients by the year 2005 in order to meet the global "3 by 5" target. The challenges threatening to undermine this noble goal in Kenya are a shortage of skilled health workers, as well as the difficulty of sustaining the supply of essential commodities. Reproductive health is one of the key priorities on our country's health agenda. Indeed our maternal mortality rate of 590 per 10 000 live births is unacceptable, considering that over 90% of these deaths are due to preventable causes. As a signatory to the Millennium Development Goals agenda, our country is fully committed to ensuring safe motherhood and child survival. To do this, we urgently need resources to improve and equip our facilities, and to develop a comprehensive referral system. Malaria continues to claim 26 000-30 000 lives every year in my country, mostly children and pregnant women. Our prevention and treatment strategies are seriously challenged by difficulties in controlling the mosquito vector and increasing resistance of the malarial parasite to drugs. We have changed our policy to respond to these by strengthening the use of insecticide residual spray, emphasizing the importance of insecticide-treated bednets and including artemisinin-based combination therapy in first-line treatment. However, these strategies are costly to sustain, even with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria: hence our appeal for international assistance.

In pursuance of the primary health care goal, the Government of Kenya is in the process of establishing a national social health insurance scheme that will provide cover for all. We have also recently launched a programme to revitalize health services in urban centres, to address the needs of the underprivileged and the urban poor. The major challenges we face in improving access to health services include the need for more health personnel, sustaining supplies to health facilities, and improving the referral system. The Kenyan Government has also increased the budgetary allocation for health from 5% of total government expenditure in the year 2000 to 7.2% in this financial year, and with the introduction of the social health insurance scheme, we expect to surpass the 15% mark, in line with the Abuja Declaration on Roll Back Malaria in Africa.

The PRESIDENT:

Thank you, honourable delegate of Kenya. I want to compliment you on the introduction of new road safety laws and control of HIV/AIDS as a priority activity. Your system of malaria control is noted and your increased expenditure on health is complimented.

Mr DE SILVA (Sri Lanka):

I bring greetings from Her Excellency President Chandrika Bandaranaike Kumaratunga and the people of Sri Lanka. They join me in expressing appreciation of the valuable technical assistance afforded by WHO over the years, which has enabled Sri Lanka to achieve tremendous gains in the field of health, giving us a special place on the world health map. As a result of the peace process initiated by Her Excellency the President, we have been able to embark upon rebuilding the infrastructure in conflict areas with the support of the international community and with special emphasis on the health sector. My Government, which took office after the elections of April 2004, is sincerely dedicated to uplifting the quality of health care for all Sri Lankans with special emphasis on those in the conflict areas.

We thank Dr Lee for his inspiring address, which highlights both global challenges and ways ahead, and especially current developments in the fight against HIV/AIDS, which is a main theme of this Health Assembly. Against the backdrop of a global epidemic, Sri Lanka is classified as a country with a low prevalence of HIV infection, which is estimated to be 0.06%. Starting from the first case of

HIV/AIDS in 1987, the number of cases has increased gradually. A cumulative total of 539 HIV-positive people have been detected so far. One hundred and sixty of them have developed AIDS and 121 of them have died. Sri Lanka was one of the first south Asian countries to ensure blood safety. Screening of donor blood for HIV antibodies was started in 1987 and today it is mandatory to do so. Up to now, only one HIV case has been reported following blood transfusion. The male to female infection ratio was 4 to 1 at the beginning: it is now 1.4 to 1, increasing the potential for mother-to-child transmission. A National AIDS Committee steering the National STD/AIDS Control Programme has developed a National AIDS Policy. STD/HIV services are delivered through a network of peripheral clinics. The central complex in Colombo houses the National Reference Laboratory for STD/HIV/AIDS.

In keeping with government policy, all HIV-infected patients requiring institutional care are admitted to normal hospital wards. Domiciliary care, however, is encouraged. National guidelines on clinical management of HIV/AIDS have been developed. Counselling services for patients and their families and facilities for HIV testing are provided. The Government has recognized the need to provide antiretroviral therapy to HIV-infected persons; the issue is the cost involved. However, antiretroviral drugs are provided for the prevention of mother-to-child transmission and for post-exposure prophylaxis following accidental exposure in health care settings. Recognizing Sri Lanka's commitment to HIV/AIDS prevention, the World Bank, for the first time in its history, has awarded a grant of US$ 12.6 million to fund a national HIV/AIDS prevention project – a comprehensive multisectoral programme being implemented between 2003 and 2008. It is designed to strengthen the preventive programmes for highly-vulnerable populations through the participation of both government and nongovernmental organizations. It also plans to enhance the commitment of political leaders and reduce stigma and discrimination associated with HIV/AIDS.

Although Sri Lanka has all the ingredients to precipitate an epidemic, prevalence is low, and we have the potential to prevent a generalized epidemic. With its deep historical commitment to human development, highly-literate population, and well-developed health infrastructure, the country is in a strong position to control and contain the spread of HIV. The Government of Sri Lanka, at its highest level, has repeatedly declared its commitment to draw on these strengths to address the issues related to the prevention and control of HIV/AIDS. Although financial constraints are our challenges, to sustain our control efforts United Nations agencies like the World Bank and WHO have come to our rescue.

Having had the rare privilege of becoming the Minister of Health for a third time in Sri Lanka, I have no hesitation in pledging my commitment and my Government's commitment to sustain our success in the control of HIV/AIDS. With the assistance extended by WHO and other funding organizations I am certain that Sri Lanka will go from strength to strength to ensure a HIV/AIDS-free nation for its people. Let me take this opportunity to congratulate Dr Samlee Plianbangchang, with whom I worked closely in the field of health when I served on the Executive Board of WHO for three years, on his appointment as the new Regional Director for South-East Asia. I have no doubt that he will continue to support the excellent work done by the WHO country office in Sri Lanka.

The PRESIDENT:

Thank you very much, honourable delegate from Sri Lanka for your commitment to improve health care in your country.

Mr BOGOEV (Bulgaria):

Allow me to express the deepest gratitude of the Government of the Republic of Bulgaria to WHO for the active expert and technical support it provides to us in the process of implementing comprehensive health-care reform in our country. The global AIDS epidemic has gone beyond health: it nowadays impacts on the demographic, economic, social and ethical dimensions of modern society. In recognition of this, Bulgaria has joined the Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly, which is an historic chance for countries, no matter whether

rich or poor, big or small, to mobilize all available resources in order to face and eliminate this danger for mankind.

Today, Bulgaria is among the countries with low incidence of AIDS. So far, we have a total of 479 cases of people living with HIV, although we are in a region with fast-growing epidemics. The Ministry of Health provides free-of-charge antiretroviral therapy to all AIDS patients in the country, the annual overall cost of one patient being around US$ 12 000. The Republic of Bulgaria supports the WHO "3 by 5" initiative and declares its willingness to be included in the list of countries that wish to receive medications for antiretroviral therapy. Bulgaria will also support a regional initiative for decreasing the prices of the drugs necessary for AIDS treatment.

Each AIDS epidemic obliges respective societies to deal with complex and difficult social and ethical issues; however, AIDS is first of all a health issue. In a number of countries, HIV infection happens due to lack of strict adherence to hygiene requirements in hospitals, unmonitored blood transfusion and other weaknesses in the health care system. Sometimes, however, it is presented as being due to medical failures: accusations are being raised and lawsuits undertaken. Even now, in certain countries, there are attempts to attribute a criminal character to the causes for the spread of AIDS disease, instead of analysing and intervening in the public health system to correct its real weaknesses. We think that substituting health problems with non-medical issues and considerations in no way helps to decrease the threat of AIDS epidemics, especially when a society needs the help of the international health community. Taking the problem out of its medical context does not serve the interests of society or safeguard the life and well-being of its citizens; it may, however, damage both social and international relations.

We look forward to hosting in June, in the capital of Bulgaria, Sofia, the regional meeting for countries of eastern Europe and central Asia that have received support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. We see this as recognition for our country and as a strong encouragement for the integrated efforts of the Member States of WHO in the framework of the procedures and policies of the Global Fund.

The PRESIDENT:

Thank you very much, the honourable delegate of Bulgaria. We compliment Bulgaria for providing free of charge antiretroviral therapy for the unfortunate victims of HIV/AIDS.

La Dra. FORERO UCRÓS (Colombia):

Señor Presidente: Hago propicia, en primer lugar, la oportunidad para excusar al señor Ministro de Protección Social de Colombia, Dr. Diego Palacio, quien en principio había anunciado su participación en esta magna Asamblea Mundial de la Salud, pero quien lamentablemente por razones de fuerza mayor no pudo acompañarnos en esta importante reunión. En nombre del Gobierno de Colombia hacemos llegar al señor Director General de la Organización Mundial de la Salud, Dr. LEE Jong-wook, nuestros mejores deseos por el éxito de esta 57ª Asamblea Mundial de la Salud.

Haciendo mención a un tema fundamental en materia de salud como es el VIH/SIDA, queremos manifestar que Colombia es signataria de la declaración de compromisos en VIH/SIDA establecida en el año 2001, y comparte los esfuerzos que viene haciendo la OMS para que haya un tratamiento efectivo a través de alianzas y servicios de salud. Al respecto Colombia ha realizado avances específicos en cuanto a buscar ampliación del acceso a la atención y el tratamiento.

En relación con el acceso a medicamentos antirretrovirales, éstos son garantizados por el sistema de aseguramiento y por lo mismo no existe un sistema centralizado de compras. El país actualmente da cobertura aproximada a 9000 pacientes, que representan aproximadamente un 50% de las personas que lo necesitan. La política del Estado apunta a garantizar el acceso universal a medicamentos de diversas fuentes (marca y genéricos) y a bajo costo.

En desarrollo de esta política, se tiene constituido el Fondo de medicamentos, que con aportes del Ministerio de la Protección Social busca, a través de adquisiciones por volumen, obtener los mejores precios del mercado como mecanismo, para volverlos más accesibles a las Direcciones Territoriales de Salud. Por otra parte, el gobierno colombiano impulsó las Negociaciones de Lima,

con el fin de obtener precios más favorables, logrando una reducción sustancial en algunos de ellos, lo que podría representar un incremento equivalente a 150 000 pacientes más, bajo tratamiento antirretroviral con triple terapia en la región. Por último, el Ministerio de la Protección logró un acuerdo con el Gobierno del Brasil para asistencia técnica en el manejo de medicamentos genéricos de calidad, que incluye la donación de medicamentos para 100 pacientes durante un año. Esto respecto a la función de liderazgo promovido por el sector de la salud pública en la ampliación del acceso a la atención y el tratamiento.

En cuanto al reforzamiento de la capacidad de los servicios de salud para ampliar la administración del tratamiento, ésta está a cargo de los diferentes actores, entre los que se cuentan diferentes aseguradoras cuya función está regulada por el Estado. Las aseguradoras tienen la obligación de garantizar unos mínimos de atención contemplados en las Guías de Atención Integral. Dado el alto costo que representa el manejo de la enfermedad, el Consejo Nacional de Seguridad Social, mediante el Acuerdo 245 de 2003 estableció un Modelo de alto costo para VIH/SIDA, que es ante todo un modelo financiero para derivar equitativamente los costos de la atención de las enfermedades de alto costo, que pretende equilibrar las cargas financieras del sistema, dando incentivos a las empresas promotoras de salud eficientes, fortaleciendo los sistemas de vigilancia y generando un modelo de atención con revisión normativa de las guías de manejo de la enfermedad. Consideramos de vital importancia la movilización internacional de asociados y recursos financieros para ampliar el acceso al tratamiento contra el VIH, si se tiene en cuenta que en Colombia se tipifica la epidemia como «concentrada».

La salud sexual y reproductiva se considera como una de las prioridades máximas de salud pública, y se ha elaborado y difundido una política que recoge las principales recomendaciones de la declaración de compromiso en VIH/SIDA tanto en aspectos preventivos como de tratamiento. Sin embargo, indiscutiblemente son los medicamentos con US$ 24 millones (y más del 53%), el rubro número uno de gasto en el país. Le sigue el gasto en personal de salud (con US$ 4,7 millones) y muy de cerca la Asesoría e Investigación (con US$ 4,69 millones). Lo anterior muestra de alguna manera, que los énfasis en salud en el país siguen recayendo en un paradigma asistencial, más que de promoción y prevención.

Las condiciones de pobreza o marginalidad de por sí son un factor más de vulnerabilidad. El SIDA puede arraigarse allí donde las condiciones sociales le quitan relevancia al tema. A su vez, el aumento de casos en una comunidad dada contribuye a agravar la situación social. Desde esta perspectiva, la prevención del SIDA debe abordarse como una respuesta integral, donde los distintos actores contribuyan a movilizar los recursos necesarios para la prevención y a evaluar el impacto económico y social de la epidemia.

Finalmente, consideramos fundamental la labor que pueda adelantar la OMS para mejorar la eficacia de los sistemas de salud en los distintos países, teniendo en cuenta la equidad y la justicia social como principios orientadores de los programas e iniciativas de la Organización, que Colombia comparte y con las cuales manifiesta su decidido compromiso. Retomando las palabras del Dr. LEE, deseo manifestar que todos los aquí presentes debemos ser portadores de esperanza y esforzarnos en nuestro trabajo por la salud en el mundo.

The PRESIDENT:

Thank you very much, the honourable delegate of Colombia. We will miss the Minister of Colombia's presence; I hope you convey this to the Minister. We note your concern over reduction of drug prices and social justice.

Mr MUHWEZI (Uganda):

I bring you greetings and best wishes from my President and the Government of the Republic of Uganda. Exactly 17 years ago, at the Fortieth World Health Assembly – as honourable ministers who were there may recall – my predecessor, the Minister of Health from Uganda, announced from this podium that Uganda had a problem of HIV/AIDS in the country and that we needed help. At that time, it is to be recalled, a number of African delegations criticized Uganda for admitting that an African country had a problem with such a shameful disease and said that we had brought shame to Africa. Of course, we all now know that Uganda was correct to take that bold decision to admit that HIV/AIDS was a real problem and that we needed urgent help. May we recount to you briefly the pillars of Uganda's struggle with this terrible epidemic.

The first one is political will and leadership. It was the visionary leadership of President Yoweri Kaguta Museveni who recognized that HIV/AIDS was a health, social and development problem. The disease AIDS had no cure and the key thing to do was to warn the country that there was a big problem in our house which could only be controlled by making everyone aware of what the problem was and what everyone needed to do to avoid it. As President Museveni himself said, he sounded the alarm loud enough for people to stand up against HIV/AIDS. President Museveni led from the front and went all over the country, warning the population about HIV/AIDS. He also mobilized other political leaders at different levels in the country including leaders in all sections of society such as religious, cultural and traditional leaders, to talk about HIV/AIDS. He did not just talk. He was also personally involved in working with the professional carers to design the technical response.

This takes me to the second pillar of our struggle: technical leadership and professional will. In order to translate the vision of the President into practical and effective action, it was necessary to produce strategies and plans and, of course, to implement them successfully. This is where our experts in various fields made their entry: from biomedical sciences, from social and behavioural sciences, faith-based groups and so on. Appropriate messages based on local knowledge were designed, packaged attractively and disseminated massively through all media channels, religious and social gatherings. No opportunity was missed to convey the message about this new terrible disease. On top of universal awareness, world-class centres of excellence were developed for research, blood transfusion, treatment and communications. New laws were enacted in respect of age of consent and marriage, rape and defilement.

The third pillar was resource mobilization. It is important to point out that the initial response in Uganda was launched using our own resources. The awareness campaign did not cost us so much money at the beginning because it was mainly about talking and publicity, using public media channels, public gatherings and civil servants already in government service. Later, however, the international community was brought in to finance the more complex interventions such as research, blood transfusion, centres of excellence and treatment programmes. We borrowed money from the World Bank and received grants from a number of friendly governments.

Fourth was community response. As a result of the above-named interventions, there was a change in the behaviour of people in respect of their sexual practices. The behavioural change was towards more responsible sex, namely a delayed sexual debut among the young, faithfulness – which is called "zero grazing" – among the sexually active, and the use of condoms by those who could not practise the first two. This is what has now become widely known as "Abstinence, Being faithful and Condoms", or "A B C". On top of this, coordination mechanisms were put into place to ensure that multisectoral and multiple players could all be pulling in the same direction. Thousands of civil society groups have been formed and are participating in prevention, care, treatment and social support. The guiding principles of our struggle, from the beginning, have been openness, inclusiveness, inventiveness and excellence. People living with HIV/AIDS have always played a key role. This, of course, was not all plain sailing. There were many challenges such as disinformation, false claims of cures and shortage of resources. Coordination of the multiple players is also an ever-present challenge, but we use dialogue to manage our difficulties and a high level of trust has been built up within the partnership structures that we use.

What is the present status of our response to HIV/AIDS in Uganda? We have reduced prevalence from 30% in some parts of the country to a national average of 5%. We have recently

completed a review of our national strategic framework to take into account the current state of the epidemic so that our interventions in prevention, care, support and treatment are responsive. We have mobilized resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, the USA President's Emergency Plan for AIDS Relief, *Médecins sans Frontières*, the German Government agency Deutsche Gesellschaft für Technische Zusammenarbeit, other partners and, of course, our own Government, so that all those who need antiretrovirals will now access them free of charge. We are carrying out a national sero-survey to establish a population-based prevalence level which will provide us with the most reliable status of the epidemic. We are participating, with the international community, in research for a vaccine and we are updating our health sector strategic plan to enable our health system to integrate HIV/AIDS work with other areas of work. The role of partners like WHO, UNAIDS and others in our struggle is commendable.

While we must do everything possible to fight HIV/AIDS we must not forget other key diseases, especially malaria, which is the leading killer in most African countries. Dr Lee Jong-wook, our Director-General, told us yesterday that when one person dies it is a tragedy, but when a million die, it is a statistic. Malaria, tuberculosis and HIV/AIDS kill six million people annually. If the international community cannot stop this, we are all guilty of genocide by omission.

In conclusion, I am happy to report on behalf of the President of the people of Uganda that Uganda has ably demonstrated that HIV/AIDS can be controlled in Africa. We have also demonstrated that the strategies which have worked for HIV/AIDS can work for other health and development programmes. It is for this reason that the Government and people of Uganda are happy to share this success with the rest of Africa and the world. We are also offering the services of our Director-General of Health Services, Professor Francis Omaswa, to fill the vacancy in the post of Regional Director for Africa when Dr Samba retires. We are convinced that he will provide the leadership that is needed by the continent and the international community as we combat HIV/AIDS and strive to achieve the Millennium Development Goals.

The PRESIDENT:

I thank the honourable delegate of Uganda. Uganda has made a brave stand and also a correct stand, as asking for help needs bravery. Political advocacy is critical in solving the health problems of the world. We compliment President Museveni on his commitment and conviction to fight the dreaded HIV/AIDS disease. Uganda is to be complimented on its determination and tremendous work to control the HIV/AIDS disease with scarce resources.

Mr PASSECHNIK (Ukraine):
Г-н ПАСЕЧНИК (УКРАИНА):

Уважаемый Генеральный директор, уважаемый г-н Председатель, члены Президиума, уважаемые делегаты.

Украинская делегация благодарит Генерального директора за содержательное выступление, в котором он затронул наиболее важные, животрепещущие проблемы современного здравоохранения. Многие из этих проблем актуальны для нашей страны.

Поскольку дискуссию на Пятьдесят седьмой сессии было предложено сосредоточить на теме "ВИЧ/СПИД", позвольте остановиться на этой исключительно важной для Украины проблеме.

В Украине инициатива Всемирной организации здравоохранения "3 к 5" рассматривается как важный рычаг в реализации доступности лечения, поддержки и ухода за больными СПИДом.

По оценкам ВОЗ, в настоящее время в Украине нуждаются в лечении около 15 тысяч человек. Несмотря на то, что государственное финансирование мероприятий на борьбу со СПИДом увеличивается из года в год, в том числе и на специфическое лечение, бюджет системы здравоохранения не в состоянии обеспечить финансирование антиретровирусной терапии для всех нуждающихся.

Поэтому программой, финансируемой Глобальным фондом, предусматривается расширение в Украине антиретровирусной терапии для 4000 человек уже в текущем году.

Для Украины самой главной задачей на сегодня является доступность лечения. Политическая приверженность руководства страны, а также серьезная законотворческая работа легли в основу ответа на эпидемию, в частности в направлении расширения доступа к лечению.

Одним из важных компонентов национальной политики в области расширения доступности лечения является принцип равного доступа к медицинской помощи представителей уязвимых групп, независимо от их социального положения в обществе.

Одним из факторов доступности антиретровирусной терапии является стоимость ее годового курса. В 2002-2003 гг. она составляла 10 тыс. долл. США. В результате усилий правительства Украины стоимость годового курса терапии снизилась в 8-10 раз. Особенное внимание уделяется производству антиретровирусных препаратов собственными фармацевтическими заводами.

В настоящее время с целью обеспечения комплексного подхода к лечению, уходу и поддержке пациентов правительство установило тесное партнерство с Всемирной организацией здравоохранения, Программой ЮНЭЙДС, Глобальным фондом, неправительственными организациями, в частности Всеукраинской сетью людей, живущих с ВИЧ/СПИДом, и частным сектором.

Исходя из важности усиления кадрового потенциала для оказания помощи ВИЧ-инфицированным, в рамках совместного проекта ВОЗ и правительства Германии в Украине создан региональный информационно-обучающий центр по вопросам оказания помощи и лечения. Центр призван стать важной движущей силой достижения целей совместной инициативы ВОЗ и программы ЮНЭЙДС "3 к 5" в Восточной Европе и Средней Азии.

В настоящее время украинские эксперты совместно с экспертами ВОЗ работают над созданием национального комплексного плана лечения, который включает планирование потребностей в антиретровирусной терапии, обеспечение лабораторий и центров по СПИДу современным оборудованием, внедрение эффективной системы эпидемиологического мониторинга, введение программ заместительной терапии.

Для внедрения комплексного плана лечения и профилактики Украине нужна поддержка многих партнеров. Правительство Украины имело возможность убедиться в том, какой значительный вклад в обеспечение процесса лечения, ухода и поддержки могут внести неправительственные организации на примере сотрудничества с Всеукраинской сетью людей, живущих с ВИЧ. Совместные усилия необходимы и для продолжения переговоров по дальнейшему снижению стоимости терапии.

Уважаемый г-н Председатель.

Уроки, полученные за годы реагирования на эпидемию, дают основания сделать вывод о том, что вся система оказания помощи ВИЧ-инфицированным и больным СПИДом нуждается в тщательном анализе и совершенствовании.

В заключение я хотел бы подчеркнуть, что эпидемия ВИЧ/СПИДа бросила вызов всему человечеству. Как мы все понимаем, ВИЧ нельзя победить в одной стране или при помощи универсального рецепта. Для этого очень важна консолидация усилий стран-реципиентов и доноров, а также усиление потенциала Всемирной организации здравоохранения в странах. Считаем, что именно инициатива "3 к 5" должна стать эффективным инструментом обеспечения широкомасштабного современного лечения во многих странах.

Благодарю за внимание.

The PRESIDENT:

Thank you, the honourable delegate of Ukraine. Your comments on the cost of therapy for HIV/AIDS are noted.

Dr AGARWAL (India):

The key challenge that every developing country is facing today is the one relating to access to good-quality health care for the people at large and at prices that are affordable to them. While technological innovation has undoubtedly contributed to the lengthening of life and good health, it is worrying that several millions in most countries of the world continue to suffer for want of access to simple and low-cost interventions, further aggravated by poverty, malnutrition, illiteracy, low status of women and environmental degradation. It is therefore heartening to see a positive attempt being made to achieve a global understanding and agreement, not only to reduce absolute poverty but also its associated manifestations, namely ill-health, illiteracy, malnutrition and low self-esteem. It is significant that at important international meetings such as the Okinawa meeting of G8 countries, the Monterrey International Conference on Financing for Development and the World Summit on Sustainable Development to name a few, resolutions were passed recognizing the need to focus on health as an important prerequisite for reducing poverty and stimulating growth and development. The United Nations Millennium Declaration is the most important outcome of this new thinking among the leaders of world community. In this connection it would be pertinent to recall the leadership and vision shown by WHO in encouraging countries to establish national commissions on macroeconomics and health to be co-chaired by the finance and health ministers. In India too, we have constituted the National Commission on Macroeconomics and Health with a clear mandate to make evidence-based arguments for investing in health by underscoring the centrality of health to the process of development and poverty alleviation. The challenge will be to find the resources and increase health spending – a difficult task, given the fact that all developing countries account for about 11% of global health expenditure although they have 85% of the disease burden.

India, a large country of one thousand million people, represents huge diversities. While in some parts of the country communicable diseases like malaria and tuberculosis continue to be the leading causes of death, in others there is a rapid increase in noncommunicable diseases like diabetes, cardiovascular diseases and cancer. Enveloping all these is the spectre of HIV/AIDS which has the potential to cast a very heavy and unbearable burden of human suffering if not effectively contained. This dual burden of infectious and communicable diseases along with lifestyle diseases is indeed a cause for concern. However, past investments in the designing and launching of sound strategies for reducing tuberculosis, malaria, leprosy, HIV/AIDS, etc. are beginning to pay off as we begin to see signs of these diseases being contained. Complex programmes like tuberculosis have shown extremely encouraging results: we see the doubling of cure rates to 85% under the directly observed treatment, short course (DOTS) programme. We are confident of eliminating leprosy and eradicating poliomyelitis by 2005. We have definitely turned the corner in our poliomyelitis eradication efforts and the eradication goal of 2005 has now become a clearly achievable one. Prevention efforts to check the spread of HIV/AIDS have been effectively combined with treatment programmes and the Government has announced its decision to provide antiretroviral treatment to about 100 000 people living with AIDS in the country. In addition to the need to control communicable diseases, the compulsion to strengthen public health surveillance has gained focus with the outbreak of the severe acute respiratory syndrome and avian influenza epidemics, as they clearly demonstrated how new diseases can adversely affect public health, trade, travel and the economy. Be it the re-emergence of old endemic diseases like plague and dengue fever or the threat of new diseases, the key clearly rests on establishing an effective surveillance system with a rapid response mechanism based on trained manpower, close monitoring of surveillance data and a network of laboratories. We are in the process of establishing such a surveillance mechanism in India with an investment of about US$ 100 million. Along with disease control, we are focused on containing the growth of population. The population stabilization programme is a high priority programme. It is one that actively involves nongovernmental bodies and the voluntary sector. A population stabilization fund under the chairmanship of the Prime Minister has been established to involve all stakeholders. Equally serious is our commitment to achieving the Millennium Development Goals related to maternal and infant mortality. In this regard, two important initiatives have been taken. One is called the "Janani Suraksha Yojna" (maternal security scheme) under which free medical advice, free treatment, monetary support for mothers' nutrition, and transportation to the health facility for a safe delivery are provided as a

package. The second is the incorporation of the private sector under the "Vande Mataram Programme". Under this Programme, private gynaecologists dedicate the ninth day of every month to providing antenatal care and advice to pregnant women free of cost. The importance of this Programme lies in its ability to expand access to good-quality care at no cost and in spreading the concept of volunteerism in achieving important national goals like reduction of the maternal mortality rate and infant mortality rate.

Equity has been a cornerstone of public policy in India. In the health sector, recent evidence showed that in several poor states there was a dearth of tertiary-care hospitals, placing a huge economic burden on the poor, who were being forced to go to cities for their care – thus incurring substantial out-of-pocket expenses. With a view to ensuring a more equitable spread of specialist care, a major initiative has been taken to establish specialty hospitals in public health in these underserved states with an investment of US$ 700 million over the next three years.

The increasing focus on food safety under the Codex Alimentarius Commission has certainly had a beneficial impact in India. A long-neglected area has now received close attention and with financial assistance from the World Bank, a capacity-building project for food and drug administration has been initiated under which the food and drug administration is strengthened, both in terms of laboratory facilities and technical expertise. These efforts are bound to help us tighten standards of food items and upgrade technology to make them more competitive. For example, standards for carbonated drinks and soft drinks have been notified and stringent laws enacted to prohibit substandard and spurious drugs, etc.

The impact of globalization has also been felt in one other area: that of traditional systems of medicine which provide cost-effective alternatives to expensive modern drugs. In India, traditional systems of medicine have widespread social sanction. Traditional Indian systems of medicine like Ayurveda, Siddha, Unani, yoga and naturopathy are now being systematically promoted to provide wider choice to patients. With a view to streamlining, standardizing and scaling up these efforts, steps have been taken to publish formularies and pharmacopoeia. Traditional knowledge of these systems has been digitized and published. These are significant attempts, as Indian systems of traditional medicine are gaining wide acceptance and popularity in other countries as well. I would like to take this opportunity to invite all of you to the exhibition on traditional Indian medicines being organized in the Mövenpick Hotel in Geneva on 20 and 21 May.

India is certainly at the crossroads, with several challenges and opportunities to improve the health status of the people in general and the poor in particular. With all projections indicating a good rate of economic growth, there is a renewed commitment to provide the quantum of resources that are necessary to initiate a process of reform in the health sector, aimed at ensuring greater equity and universal access to good-quality health care.

I consider it a privilege to be here in this august Health Assembly and share with you all, the vision that India's leadership has adopted to promote a healthy society which will be able to access the fruits of development in the most equitable manner.

The PRESIDENT:

Thank you, honourable delegate of India. Your emphasis on poverty and illiteracy – reasons of ill-health – and on surveillance of disease and population control is commendable. Your publicity for traditional medicine is also highly commended.

Professor BOUPHA (Lao People's Democratic Republic):

On this occasion, we would like to present our sincere appreciation to the new Director-General, Dr Lee Jong-wook, for having taken a promising new initiative for the world's health communities.

As we all well know, HIV/AIDS has been recognized as the most dramatic disease event of the second half of the twentieth century. According to the Global Health Council data of 2000, the total number of deaths and expected deaths from HIV/AIDS already exceeds the total killed in all the major wars of the twentieth century. The total number of war deaths was 32.8 million and the death toll from AIDS is 47.3 million. Its economic and societal impacts are particularly tragic, because 95% of HIV

infections occur in developing countries, which are least prepared. It is indeed a very great concern and sadness, knowing that nearly three million deaths each year are attributable to HIV/AIDS, despite the ability of antiretroviral therapy to reduce the HIV viral load significantly, delay progression of HIV infection to AIDS, and improve overall quality of life for people living with HIV/AIDS. The constructive initiative of WHO and UNAIDS in launching, on World AIDS Day (1 December 2003), a strategy for attaining the "3 by 5" target is absolutely rational and should become a commitment of every Member State.

Fortunately, so far, prevalence in Lao People's Democratic Republic is estimated at 0.05%, and it is classified by UNAIDS as a low prevalence country. The first case of HIV was identified in 1990 and the first AIDS case was identified in 1992. The cumulative number of HIV/AIDS cases reported from 1990 to December 2003 was as follows: 14 out of 18 provinces reported that of 98 016 blood samples, 1212 tests were HIV-positive. There were 670 cases of AIDS, and 486 deaths. However, as there were inadequate human, supply, equipment and financial resources to conduct HIV tests among the target population, unidentified latent cases might exist and might not be reported. In order to cope with this fearful disease in the past as well as at the present time, Lao People's Democratic Republic Government's policy has continuously paid very high attention to the health of the Lao people of all minority ethnic groups. Thus, prevention activities were recognized as the first, and treatment activities as the second, of the six main activities of the Ministry of Health's work plan. The National Committee for the Control of AIDS was established in 1988, followed by supporting capacity building and activities for the control of AIDS. HIV/AIDS policy has been set up and implemented since December 2001. In addition, a national strategic plan on HIV/AIDS/STD has been developed for 2002-2005. During the ongoing implementation of this strategic plan, the main activities are and will focus on capacity building; strengthening of communication, information, and education; research and surveillance; counselling and testing; and STD prevention, care and presumptive and periodic treatment are right now being conducted in one province. A 100% condom-use programme has been initiated in another province, including social marketing nationwide. Care and support for people living with AIDS, including antiretroviral treatment, is currently being developed, along with a reliable national HIV/AIDS surveillance system to more precisely determine the real status of HIV/AIDS. Through the mentioned activities we do hope we will contribute to some extent to reaching the "3 by 5" target of WHO and UNAIDS. Nevertheless, for the implementation of immediate and long-term strategic action, strong technical and managerial skills in these activities should be developed and strengthened.

As we are one of the francophone countries, allow me to conclude my statement in French.

(The speaker continued in French.)
(L'orateur poursuit en français.)

Pour conclure ma présentation, et pour saisir cette bonne occasion, au nom de la délégation de la République démocratique populaire lao, j'aimerais exprimer nos sincères remerciements à toutes les organisations internationales telles que l'OMS, l'ONUSIDA, la Banque asiatique de Développement, l'Agence allemande de Coopération technique (GTZ) avec son initiative d'appui, le Fonds mondial, l'UNICEF, Médecins sans Frontières Suisse et d'autres pour leur soutien technique et financier en faveur du développement en général et de la lutte contre le VIH/SIDA en particulier. Nous espérons avoir votre appui continu. Je souhaite à la Cinquante-Septième Assemblée mondiale de la Santé un brillant succès. Je vous remercie de votre attention.

The PRESIDENT:

Thank you, honourable delegate of the Lao People's Democratic Republic and we compliment you on the committed policy to arrest the HIV/AIDS epidemic.

Le Dr SANTANA GIL (Sao Tomé-et-Principe) :

Monsieur le Président de la Cinquante-Septième Assemblée mondiale de la Santé, Monsieur le Directeur général de l'OMS, Mesdames et Messieurs les Ministres de la Santé et chefs de délégation, Mesdames et Messieurs les délégués, permettez-moi, au nom de la délégation de la République démocratique de Sao Tomé-et-Principe et en mon nom personnel, de vous féliciter, Monsieur le Président, pour votre élection à la présidence de la Cinquante-Septième Assemblée mondiale de la Santé. Permettez-moi aussi de rendre hommage au Directeur général de l'OMS pour avoir eu l'initiative d'inclure une fois de plus dans l'ordre du jour de l'Assemblée mondiale de la Santé le VIH/SIDA en tant que thème central du débat et des tables rondes ministérielles au moment où nous assistons à des engagements sans précédent pour la lutte contre ce fléau qui fait des ravages et qui, par conséquent, continue d'être un des principaux obstacles au développement de nombreux pays, notamment en Afrique subsaharienne où se trouve notre pays, Sao Tomé-et-Principe.

La détermination de la communauté internationale dans la formulation des réponses politiques et financières à plusieurs niveaux et l'engagement adopté par l'Assemblée générale des Nations Unies à sa session extraordinaire de juin 2001 sont des témoignages de ce compromis global. Pourtant, la situation concernant la réponse mondiale à ce fléau deux décennies après le diagnostic des premiers cas de SIDA n'est pas prometteuse car, malgré l'initiative mondiale de démarches multisectorielles et les ressources mises à profit jusqu'ici, nous sommes encore loin d'atteindre le but fixé dans la Déclaration de 2003. Le VIH/SIDA continue d'être une des causes premières de décès, celle qui réduit de ce fait l'espérance de vie des populations des pays pauvres, ce qui entraîne des conséquences graves pour leurs économies. Deux décennies après le premier diagnostic du SIDA, quelle est la situation ? Plus d'un tiers des pays les plus frappés par cette maladie n'ont pas encore pu mettre en place des stratégies visant à soutenir les orphelins du SIDA ; d'autres pays n'ont pas encore adopté des dispositifs juridiques contre la discrimination envers les groupes vulnérables. Dans le continent le plus touché, sur neuf personnes qui souhaitent savoir si elles sont oui ou non séropositives, seule une a accès au dépistage. Néanmoins, les campagnes d'information et d'éducation, les comportements sexuels responsables et les pratiques sexuelles à moindre risque n'ont pas encore atteint le niveau souhaitable et la proportion de ceux et de celles qui ont accès aux préservatifs et aux services de dépistage et de conseil est faible. Cela ne permet pas d'envisager des améliorations significatives dans la situation épidémiologique du VIH/SIDA dans un horizon temporel court. Chaque jour, 8000 personnes meurent encore d'infections liées au SIDA. A peine 400 000 personnes sur les six millions avec la maladie à un stade avancé ont accès au traitement antirétroviral dans les pays en développement. Ceci est un triste scénario. Il s'agit en fait d'un scénario qui nous impose à tous une réflexion sur les politiques et les stratégies d'intervention jusqu'alors adoptées, d'un scénario qui nous pousse à définir des politiques et des stratégies qui permettront en même temps d'avoir un accès universel et équitable aux soins et services, notamment l'accès aux antirétroviraux, de combattre l'exclusion et la discrimination et de défendre les droits des malades ou des personnes affectées par le VIH/SIDA.

Le moment est venu d'analyser ensemble les principaux facteurs qui sont à la base de la réponse timide dans les pays à faible revenu contrairement à ce qui serait souhaitable à un moment où la situation d'urgence mondiale demande une réponse plus consistante. C'est le moment de nous demander dans quelle proportion les facteurs déterminants comme la pauvreté et le chômage, l'analphabétisme et le manque d'information sur les maladies dans les communautés ont eu une incidence sur les résultats escomptés. Dans quelle mesure les stratégies intégrées de réduction de la pauvreté mises à exécution dans plusieurs pays ont-elles contribué à améliorer l'accès des personnes à l'information et à l'éducation, à l'emploi et aux services sociaux ? Dans quelle mesure ces stratégies ont-elles pu assurer les appuis nécessaires et diminuer les inégalités économiques, sociales et culturelles contribuant ainsi à réduire la vulnérabilité à l'infection ? Jusqu'à quel point les responsabilités individuelles et institutionnelles ont-elles été développées en vue de renforcer les actions qui peuvent amener les personnes à adopter les attitudes et les comportements qui permettent de se protéger de façon permanente ? Si d'un côté il est stimulant de savoir que, grâce aux ressources dont on dispose déjà et à celles qui seront mises à disposition et aux efforts déployés, nous pourrons atteindre le but défini dans le cadre de l'initiative « 3 millions d'ici 2005 », d'un autre côté il est

frustrant de savoir que la grande majorité des démunis n'auront pas la possibilité de réduire leurs charges virales, de freiner la progression de l'infection et d'améliorer la qualité de vie avec l'introduction des antirétroviraux à un moment où nous défendons un droit universel, le droit d'accès aux antirétroviraux. Sao Tomé-et-Principe figure parmi les pays pauvres dont le taux d'infection est encore réduit si on le compare avec la moyenne des pays de la sous-région. On estime cependant qu'il existe dans le pays de 3600 à 6200 personnes infectées par le virus. Si des mesures énergiques, intégrées, coordonnées et durables ne sont pas mises en place en vue de contrecarrer le risque d'infection et l'impact négatif de l'épidémie, Sao Tomé-et-Principe pourrait dans les prochaines années voir l'espérance de vie de sa population réduite et son développement vivement compromis.

Le challenge du Gouvernement dont je fais partie consiste à mettre en place des stratégies permanentes qui permettront de renverser la situation dans un des pays insulaires les plus pauvres du monde où le Ministère de la Santé consacre encore ses principales ressources à la lutte contre un autre fléau dévastateur, le paludisme. Le Gouvernement cherche aussi à sensibiliser nos partenaires et à mobiliser des ressources essentielles afin d'exécuter notre politique de lutte contre le VIH/SIDA ; nous croyons en effet qu'il est possible de contribuer à diminuer le déclenchement de nouveaux cas et d'améliorer les conditions de vie et de travail au profit de l'ensemble des citoyens qui vivent avec la maladie. Parmi les facteurs qui obligent les pouvoirs publics à placer la lutte contre le VIH/SIDA parmi les priorités nationales, il faut citer la petite dimension du pays, la pauvreté qui touche 53 % de la population dont la majorité féminine supporte aussi le poids d'être la tranche de population la moins alphabétisée, la progression des relations avec des pays qui abritent un nombre croissant de personnes infectées, la tendance à l'augmentation des infections sexuellement transmissibles, la grossesse dans l'adolescence associée au faible niveau d'information, l'accroissement du nombre des travailleurs du sexe et la fragilité des services nationaux de santé. C'est ainsi que sur la base d'une approche participative et multisectorielle, incluant les différents acteurs de la vie de la nation, le secteur privé, le secteur public, les employeurs et les travailleurs, les personnes infectées par le VIH/SIDA et celles qui sont touchées par la pandémie, ainsi que nos partenaires du système des Nations Unies, a été élaboré et adopté en 2003 un nouveau plan stratégique dont la mise en place nécessite incontournablement l'appui technique et financier de nos partenaires ; nous espérons que leur présence à la table ronde thématique qui a lieu cette année permettra de concrétiser cet appui. La nécessité d'appliquer les actions prioritaires définies dans le plan cité nous amène à rechercher constamment de l'aide auprès de nos principaux partenaires et des initiatives mondiales de lutte contre la pandémie. Or le processus complexe des institutions financières et des bailleurs de fonds ainsi qu'une éventuelle baisse du taux de prévalence semblent constituer un obstacle à l'obtention des fonds. Bien que nous soyons d'accord avec la politique globale qui tend à accorder une aide prioritaire aux pays les plus touchés, nous croyons qu'il importe de ne pas négliger l'aide aux petits Etats insulaires comme le nôtre qui ont actuellement de faibles taux de prévalence, mais qui doivent faire face à un nombre important de facteurs de vulnérabilité et de risques d'infection. Nous croyons que le moment est venu d'agir avec détermination si nous voulons prévenir les graves conséquences que cette épidémie provoque et éviter ainsi une dégradation progressive et rapide des indicateurs de développement. Ceci est le cas de Sao Tomé-et-Principe qui, après avoir soumis trois propositions au Fonds mondial de lutte contre le SIDA, la tuberculose et le paludisme, a à peine réussi à être classé dans la catégorie 3. Il importe donc que soient intensifiées les occasions de mobilisation des ressources techniques et financières nécessaires pour renforcer les soins, le traitement et le suivi de la lutte contre le VIH/SIDA dans les pays démunis, même dans ceux qui ont un faible taux de prévalence.

Pour terminer, permettez-moi de manifester notre préoccupation à propos du fait que Taïwan, un de nos principaux partenaires de développement dans le secteur de santé, ne puisse encore participer en qualité d'entité de santé à l'Assemblée mondiale de la Santé. Son expérience dans la lutte contre les maladies transmissibles, tant dans son territoire qu'en collaboration avec d'autres pays et institutions, ainsi que sa contribution au mouvement mondial de lutte contre le SIDA, le paludisme et la tuberculose par la mise à disposition de ressources financières et d'expertise dans une attitude de solidarité, unissant ses forces avec tous ceux qui se sont engagés avec détermination dans la lutte contre ces fléaux, sont, nous semble-t-il, des arguments plus que suffisants pour que ce pays puisse faire partie des observateurs de l'Assemblée mondiale de la Santé. Le faire serait non seulement une

démonstration de reconnaissance pour ses contributions, mais surtout une manifestation du respect des principes fondamentaux de l'humanité et du droit à la santé. Je vous remercie.

The PRESIDENT:

Thank you, honourable delegate of Sao Tome and Principe. Your comments on screening services for improved detection are noted.

I would request delegates that when something has been decided by vote, we should refrain from talking about it because it was the august Health Assembly that decided on certain things and we should move forward.

Mr ASLAM (Pakistan):

Bismillah arrahman arrahim. Assalamu alaikum. The Pakistan delegation would like to place on record its appreciation of the excellent arrangements made by WHO in connection with the Fifty-seventh World Health Assembly. The Pakistan delegation salutes the commitment, vision and dynamic leadership of Dr Lee Jong-wook, Director-General of WHO, and his dream of making this world healthier and safer. The Director-General has unveiled his agenda of change, with a clear message to address the public health challenges in the area of noncommunicable and communicable diseases that afflict the populations of our planet. In this context, many new initiatives have either been launched or are waiting to be launched in the near future. The flagship amongst these is the "3 by 5" initiative. We are convinced that this initiative, apart from meeting its target of providing antiretroviral therapy to three million people who mostly live in poor and impoverished countries, will look ahead and develop strategies to meet the needs of nearly 40 million people who live with HIV/AIDS.

WHO was, and remains, the most important player in preventing and controlling global health threats. Successful control of the SARS epidemic and enhanced efforts to eradicate poliomyelitis are examples of strong commitment and dedication towards global health development. Recognizing the emerging threats and challenges, more and more focus is now being given to control of noncommunicable diseases, which are responsible for about 60% of mortality in the developing world. Prevention and control of injuries is another priority area where WHO is focusing its attention and it has started many initiatives with the help of partners. For the first time in the history of WHO, this year's World Health Day was dedicated to the theme "Road safety is no accident". Health promotion and healthy lifestyles, immunization, nutrition, family and reproductive health are a few other selected examples where WHO is taking a leading role.

In Pakistan, the Government has initiated civil service reforms whereby district governments have been given autonomy to make use of resources at the local level, based on the needs of the population. At the national level, policy processes are being made more inclusive and participatory, and all stakeholders are actively involved. There is greater emphasis on programmes than on projects and more dependency on national resources than on looking towards the donor community. However, I would specifically like to mention here that our flagship programme, which is changing the health and life of poor and impoverished women in Pakistan. This National Programme for Family Planning and Primary Health Care, which aims to deliver basic health services at doorsteps through deployment of Lady Health Workers, is currently covering all the districts of the country and is being implemented and monitored by more than 72 000 promising Lady Health Workers and Lady Health Supervisors. Independent evaluations have shown that these Lady Health Workers are not only agents of change in their communities, but also a source of inspiration for their fellow women.

We are totally committed to the eradication of poliomyelitis from our country by the end of this year, in tandem with the world community. This year only 12 poliomyelitis cases have been reported, as against 34 cases in the same period last year. The poliomyelitis virus has been contained in certain pockets and this gives us great hope to achieve our target.

The unanimous adoption of the WHO Framework Convention on Tobacco Control by the Fifty-sixth World Health Assembly was an historic achievement of WHO. Pakistan actively participated in the negotiations of the Framework Convention. As you may know, Pakistan is one of the largest tobacco growers in the world and stood to lose in economic terms. Strong lobbies of tobacco growers

and other stakeholders were opposing the signing of the Framework Convention. However the Health Minister of Pakistan, the incumbent President of this august Health Assembly, stood true to the words which he set out in his speech that "what is morally wrong cannot be politically right". He prevailed upon the Cabinet to authorize the signing of the Framework Convention and I am happy to announce that Pakistan has joined 110 other countries by signing the Treaty yesterday, 18 May 2004. Steps will be taken for early ratification of the Treaty.

I would like to emphasize that there are areas where we need to work together globally. We have all agreed and made a promise that, by 2015, nations will achieve the Millennium Development Goals. Let us be honest: a lot needs to be done in this regard. There is a need to develop mechanisms, processes and interventions to realize this dream but, most importantly, poor nations need more funds. This is where WHO needs to take a leading role along with national governments and lobby for more funds from the donor community and richer nations; otherwise, I am afraid that this may turn out to be another global slogan only. Vertical interventions are important and effective, but we need to move towards strengthening health systems and improving policy planning mechanisms, if we want to ensure that investment leads to sustainable development. There is a need to develop successful models at the country level. They should be replicable and affordable by most nations. I would suggest that the Health Assembly renew its call to Member States that health is the first and foremost component of socioeconomic development. An unhealthy world cannot dream of development and cannot even ensure world peace, a target towards which the global fraternity has been working hard for many decades. I am sure that when I present these concerns, I am voicing the common feelings of most Member States. I conclude my statement with the hope and trust that the Fifty-seventh World Health Assembly will provide new paths, new directions and opportunities for health for all, particularly for poor women and vulnerable groups. This will reduce the disparity among communities, populations and nations and, ultimately, improve quality of life, equity and justice.

The PRESIDENT:

Thank you, the honourable delegate of Pakistan. My compliments on the emphasis on road safety that is being pursued in Pakistan. I compliment you on the Lady Health Workers programme that takes health care to the doorstep of the poor. Eradication of poliomyelitis this year is extremely important, as is also health for the poor. We compliment you for signing the Framework Convention treaty, and I urge other countries to follow suit as per the instructions and recommendation of the Director-General.

I now give the floor to the delegate of Nigeria who will also speak on behalf of the countries of all the African Region.

Professor LAMBO (Nigeria):

Since charity begins at home, let me start my two addresses with the one on Nigeria.

My delegation wants to contribute to the debate on the Director-General's address by focusing mainly on HIV/AIDS. The prevalence of HIV/AIDS shown by our last seroprevalence study was 5.0%. This has fallen from 5.8% as reported in 2001. However, it translates into between 3.7 and 4 million people living with HIV/AIDS, mainly because of our national population. This exerts a great deal of pressure on our health system and the socioeconomic well-being of our people, with adverse effects on Nigeria's developmental efforts. To match these challenges, the President of my country, the Federal Republic of Nigeria, is totally committed to the prevention and control of HIV/AIDS and has therefore set up a multisectoral committee with membership that includes all major stakeholders. My President also chairs a Presidential Committee on HIV/AIDS, whose members are honourable ministers of the key sectors involved. There has been an increase in budgetary allocation to HIV/AIDS by the Federal Government, as demonstrated by the current treatment of over 14 000 people living with AIDS at a highly subsidized price to the patients. In addition, there are a few states in Nigeria that have their own antiretroviral treatment initiatives. They provide this treatment at subsidized prices, although the subsidy is not as high as that of the Federal Government. With a population of over 600 000 people who deserve to receive antiretroviral treatment, the number we are currently treating is

just the tip of the iceberg. We therefore welcome the "3 by 5" initiative and other initiatives that assist us to scale up the number of persons with access to antiretroviral therapy. Our plan – which I may say is very ambitious – is to scale up the treatment to 350 000 people by the year 2007. This, however, must be done within the context of the country plan and therefore as part of a comprehensive care and support programme. Consequently, we appreciate initiatives that will strengthen our capacity to coordinate all initiatives and activities. We will also welcome initiatives that have plans for sustainability beyond the initial phases.

I appreciate the fact that Nigeria is one of the six remaining endemic countries with wild poliovirus transmission. I would like to stand here and assure all Members of this Health Assembly that Nigeria is determined to meet the target of stopping wild poliovirus transmission by December 2004. Together with our partners on the Interagency Coordinating Committee, as well as states and local governments, we have put up clear and simple strategies that will involve all stakeholders, especially the communities. To implement these strategies, we will need to mobilize funds. I am pleased to inform you that the Federal Government of Nigeria has recently committed 2 billion Naira (which is about US$ 15 million) to the country's poliomyelitis eradication efforts. However, there still remains a funding gap of about US$ 52 million which we require to ensure that every child under five years is reached in Nigeria using the house-to-house strategy. We have also identified supervision and monitoring as key tools for achieving this goal.

Finally, our health systems, as has been mentioned several times by other speakers, need to be strengthened. Until and unless this is done, all our disease prevention, control and eradication efforts will not achieve the desired result. This task must be tackled head-on now. We are determined and we request the kind support of WHO and Member countries to do this as part of our comprehensive Government-led health-sector reform efforts. We will continue to expect WHO to assist us in this and some other key areas.

Thank you for allowing me to wear the first hat. I will now wear the second one. This second hat that I am wearing is the statement I am making on behalf of the WHO African Region's 46 Member States. It is an honour to make this statement on behalf of my colleagues and on behalf of our countries to this Health Assembly. Of the six regions of the World Health Organization, the African Region continues to face the greatest challenges related to health and the socioeconomic development of its people. Indeed, the highest global burden related to HIV/AIDS, tuberculosis and malaria is to be found in our Region. The loss of 2.3 million lives every year to HIV/AIDS is a catastrophe of untold proportions which causes immeasurable suffering at the individual, family and community level. The highest rates of tuberculosis globally are to be found in our Region and the close association between tuberculosis and HIV has reversed decades of progress in the control of tuberculosis. Malaria continues to ravage communities in our Region, accounting for between 30% and 50% of hospital admissions and up to 40% of public health expenditure in high-transmission areas. An African child dies of malaria every 30 seconds and 75% of all malaria deaths globally occur among African children under the age of five years. The negative impact of these diseases on development is immense. It is for this reason that the African Region has accorded high priority to their prevention and control within the context of strengthening our health systems and the development of our economies. We therefore welcome WHO's "3 by 5" initiative and its target to provide treatment to 3 million people by the end of 2005, as 2 million of these people will be from the African Region. We urge WHO and its partners to mobilize all resources necessary for the translation of the "3 by 5" targets into support for Member States to be delivered within the context of national frameworks for the expansion of access to comprehensive HIV services, and to put in place measures to ensure its sustainability beyond 2005. We welcome the generous support given by some donors to the "3 by 5" initiative. I would in this regard appeal to others to consider doing the same.

Only a few days ago, on 14 and 15 May, ministers of health of Member States of the African Union gathered in a special session to discuss the continent's response to HIV/AIDS, tuberculosis and malaria and other related infectious diseases, as well as the challenges of universal access to immunization. In our discussions we addressed the need to strengthen health systems in order to combat the wide range of diseases that we have to deal with in the context of our very limited resources. We take this opportunity to commend WHO and its partners, including the Global Alliance for Vaccines and Immunization, for their important contribution to expanded access to immunization

services throughout the continent. As Member States of the Region, we remain fully committed to the eradication of poliomyelitis and to achieving universal immunization coverage for all African children.

We are pleased to note that the agenda of this Health Assembly will address many issues of concern to the African Region. Maternal mortality remains unacceptably high and it calls for urgent and energetic action. Human African trypanosomiasis continues to be a cause of underdevelopment and human suffering in many parts of our continent. As if the challenge of all these communicable diseases were not enough, we also face a growing burden of noncommunicable diseases. Road traffic injuries, a cause of significant disability and mortality due to poor road infrastructure, robs our continent of its most important asset – that is, young people in their prime. We need to develop prevention and control strategies, as well as to strengthen the capacity of our health systems to address noncommunicable diseases, if we are to avoid these diseases becoming the epidemic of the future on our continent. We therefore congratulate the Director-General for the attention that the Health Assembly will give to these matters. We encourage these discussions. Strategies to meet these challenges will take into account the context within which our economies and health systems will need to address them.

2003 was an historic year for WHO, being the year in which the first formal health treaty, the WHO Framework Convention on Tobacco Control, was successfully negotiated and unanimously adopted by this Health Assembly. Implementing this treaty has the potential to significantly reduce the burden of noncommunicable diseases related to smoking. Member States of the WHO African Region therefore take this opportunity to encourage all Member States that have not yet signed and ratified the Framework Convention to do so in order that it may come into effect at the earliest opportunity. We note that to date, 26 African countries have signed, and one has ratified, the Framework Convention. We are confident that many will sign before the deadline of 29 June 2004.

Human resource capacity is one of the greatest challenges faced by health systems in Africa. As Member States, we accord high priority to the development of human resources and this has been an area of major investment in the context of our limited resources. This challenge, unfortunately, has been worsened by the migration of professionals to developed countries. We therefore invite WHO and its Member States, within the context of health system development, to assist the countries and the Region to find viable and fair solutions to this problem. Consequently, we urge Member States to support the draft resolution that will be tabled on this subject.

I would like to thank WHO for its support to Member States of the African Region in pursuit of better health for the peoples of Africa. I wish, in particular, to express our appreciation for WHO's efforts to mobilize resources to address global health challenges. We also encourage WHO to continue to provide technical support to access resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Let me take this opportunity to assure you of our resolve, as a Region, to commit a significant proportion of our own resources to health: in this context, Member States agreed to allocate at least 15% of their national budget to the health sector. This position is reflected in the 2000 Abuja Declaration, was reaffirmed in Maputo at the Heads of State summit in 2003 and will be integrated into the development strategy for the African continent, that is the New Partnership for Africa's Development (NEPAD). While our Region is faced with tremendous challenges, we firmly believe that these are not insurmountable and we are convinced that, with committed support from WHO, we will achieve significant progress in protecting and promoting the health of the African populations.

I wish to end our statement by paying tribute to a distinguished son of Africa who has dedicated his life to improving the health of Africa's people. This will be the last Health Assembly for our Regional Director, Dr Ebrahim M. Samba, in his present capacity. On behalf of my colleagues, fellow ministers and indeed on behalf of all the people of WHO's African Region, we salute him for his tremendous contribution over a particularly challenging period.

The PRESIDENT:

Thank you the honourable delegate of Nigeria. I commend you on the tremendous work done on the control of HIV/AIDS and I compliment the political advocacy of your President and yourself. In my personal experience, you have a committed personality and I am sure Nigeria's health is in safe

hands. Your point that health systems have to be strengthened is noted. Also, the African health ministers' meeting that you talked about will, I think, strengthen cooperation and this kind of cooperation will definitely benefit the whole continent of Africa. I am glad most of the African countries have signed the Framework Convention: I hope that others will follow.

Le Professeur DUSHIMIMANA (Rwanda) :

Monsieur le Président de la Cinquante-Septième Assemblée mondiale de la Santé, Monsieur le Directeur général de l'OMS, Mesdames, Messieurs les Ministres de la Santé, Mesdames, Messieurs les chefs de délégation, permettez-moi, Monsieur le Président de l'Assemblée, de me joindre aux autres orateurs pour vous féliciter de votre élection à la tête des présentes assises. Je voudrais également profiter de l'occasion pour féliciter le Directeur général pour ses débuts de fonction qui sont prometteurs et rassurants.

Monsieur le Président de l'Assemblée, le VIH/SIDA reste, à côté du paludisme, à la tête des problèmes majeurs de santé au Rwanda, avec une prévalence qui oscille autour de 13,5 % de la population totale. Le Gouvernement rwandais en est conscient et le prend comme problème numéro un à résoudre et s'engage résolument à le combattre. Pour cela, il a créé au sein du Ministère de la Santé un secrétariat d'Etat qui doit s'occuper spécialement du VIH/SIDA ; comme ce dernier dépasse le cadre médical, il a créé également au sein de la présidence de la République une commission nationale de lutte contre le SIDA, dont le rôle principal est la mobilisation sociale de toutes les couches de la population rwandaise. A côté de cette commission existe un centre de traitement et de recherche sur le VIH/SIDA qu'on appelle en abrégé TRAC. Toutes ces institutions rencontrent d'énormes problèmes dans la lutte engagée contre ce fléau, notamment ceux qui sont relatifs aux ressources humaines, matérielles et financières. La coopération bilatérale et multilatérale est venue appuyer le Rwanda, et c'est ainsi que nous bénéficions des interventions du Fonds mondial de lutte contre le SIDA, de la Banque mondiale, du PNUD, de l'USAID, du Département pour le Développement international du Royaume-Uni, du plan d'urgence pour la lutte contre le SIDA proposé par le Président des Etats-Unis d'Amérique et, bientôt, de la Banque africaine de Développement. Grâce à ces interventions, nous pouvons nous trouver dans une position confortable dans l'initiative « 3 millions d'ici 2005 » puisque, d'ici 2005, on aura sous traitement 47 000 patients-VIH sur un total d'environ 110 000 malades. L'utilisation rationnelle, efficiente et adéquate des fonds en provenance des partenaires exige une coordination étroite, transparente et engagée pour que toutes les interventions à réaliser entrent dans le plan stratégique et le plan d'action des pays, ce qui permettra de rester dans les priorités et d'atteindre les vrais bénéficiaires. Toutes ces ressources, qu'elles proviennent des partenaires ou qu'elles soient des ressources nationales, doivent être réparties équitablement sur tout le territoire national pour garantir l'équité dans la fourniture des soins de santé aux populations. Le constat actuel révèle que, dans de nombreux pays, surtout ceux en voie de développement, plus de 70 % de ressources, toutes confondues, sont utilisées dans les zones urbaines, alors que plus de 85 % de la population vit dans des zones rurales avec des conditions sanitaires plus difficiles et des systèmes de santé les plus déficients.

Monsieur le Président, je ne pourrais terminer mon propos sans dire un mot sur la médecine traditionnelle. Dans de nombreux pays en développement, une grande partie de la population fréquente la médecine traditionnelle puisque celle-ci est disponible, accueillante et accessible. La médecine traditionnelle est efficace pour un certain nombre de problèmes de santé, mais elle est aussi à l'origine de pas mal de problèmes de santé ; ce qui demande que l'on manifeste un intérêt assez important pour l'encadrer, la promouvoir et profiter de son côté positif tout en réduisant son impact négatif sur la santé des populations. J'en profite, Monsieur le Président, pour demander aux Etats Membres, à l'OMS et à d'autres partenaires, de mener des recherches approfondies et de définir des programmes d'échanges d'expérience dans ce domaine pour améliorer la santé de nos populations respectives. Je vous remercie de votre attention.

Dr DUFLE (Somalia):

Bismillah arrahman arrahim. I am honoured and humbled to have been accorded the privilege to address this esteemed Health Assembly and I am pleased to extend to you my warmest greetings

and to express, in my name and on behalf of the Transitional National Government of Somalia, our sincere gratitude and appreciation to the World Health Organization for all the efforts it exerts in the alleviation of the suffering of people all over the world.

As you know, in Somalia the country's health infrastructure has been shattered following protracted civil strife. The extremely limited capacity of the Ministry of Health to deliver health care and the increasing need for this care as a result of widespread poverty and deprivation makes the country fertile soil for the spread of all kinds of diseases and ill-health. Women and children are the groups most vulnerable to the deteriorating physical and psychological conditions that prevail in present-day Somalia.

Currently, the major health problems Somalia faces come in the form of tuberculosis, cholera, HIV/AIDS, meningitis, vaccine-preventable diseases (especially measles), diarrhoeal diseases (especially among infants), malaria, and leishmaniasis, tetanus, sexually-transmitted diseases, respiratory infections, common obstetrical problems and anaemia. Emergencies and crisis outbreaks of cholera, measles and meningitis are common in all regions of Somalia. The large numbers of internally-displaced people in Somalia and the squalid conditions they live in, especially in the large cities like Mogadishu, is another dangerous dimension of the serious health hazard the country faces. Somalia has one of the highest maternal mortality rates that we know of: 1600 per 100 000 live births. The high rate is primarily related to the limited access of pregnant women to trained midwives and the non-availability or limited utilization of referral services. The midwifery profession is one of those that has suffered the biggest attrition in terms of numbers. Many midwives left the country after the civil war and those who were left behind are getting old; thus the number of midwives has decreased dramatically. Somalia has a high incidence of tuberculosis. The estimated rate of all tuberculosis cases is 162 per 100 000 of the population. Every year, 21 000 people are estimated to develop tuberculosis in the country; 80% of the cases occur in the productive age groups (between 15 and 44 years of age). Tuberculosis is therefore an important public health problem. Malaria is considered a major health problem, affecting all strata of the Somali population. Transmission dynamics at the regional level are more complex because of the climatic conditions and demographic structure. Social disruption, war and lack of public health infrastructure add further complexity to the situation.

The estimated number of HIV/AIDS sufferers in the country is 43 000. Available data for 2003 showed a prevalence of 1% among antenatal care attendants. These data are not representative. However, taking into consideration the prevailing situation in Somalia, this prevalence can be considered as a serious indicator. Data coming from blood screening centres showed that 0.8%-1% is positive. Somalia has a very high prevalence of tuberculosis, a situation that will be further aggravated by HIV/AIDS. Ongoing civil strife has resulted in the destruction of infrastructure and the livelihood of large masses of the population, forcing them to move from rural to urban areas and to neighbouring countries with great disruption of social bonds, a phenomenon that is well known for increasing HIV spread. The Somali authorities have expressed their strong commitment to support the HIV/AIDS programme. HIV/AIDS prevalence in Somalia is currently estimated to be low. However, WHO and UNICEF suggest that Somalia should be classified as a country with a "generalized HIV epidemic", based on other available proxy indicators. In addition, there is much cross-border migration of Somalis within Somalia and in the border areas with neighbouring countries which have a high prevalence rate. Chronic conflict, poverty, and the return of refugees from neighbouring countries all represent serious risks for an explosive expansion of the epidemic in Somalia in the near future.

Somalia is particularly vulnerable to the occurrence of epidemics due to several factors, including civil strife, a poorly-functioning public water supply, large numbers of internally displaced people, the high prevalence of malnutrition, the destruction of most of the health services infrastructure and the loss of the majority of professional staff. This situation favours the occurrence of epidemics and hinders control efforts. Cholera has been endemic in Somalia since 1994, with huge annual epidemics. The first epidemic of meningococcal meningitis ever reported in Somalia hit Hargeysa in late 2001 and early 2002. The huge epidemic of Rift Valley fever which affected the country in 1997 and 1998 still exerts its economic consequences due to embargoes on Somali livestock trade. Other epidemic-prone diseases, such as viral hepatitis, leishmaniasis, measles and malaria, have also been a great burden in terms of morbidity and mortality.

Somalia's human resources for health have been severely affected by 14 years of conflict. As expected, there has been a dramatic loss of qualified health professionals in many different parts of the country. At present, there is a severe shortage of qualified health professionals, especially medical doctors, nurses, midwives and allied health professionals. Many of the medical doctors, nurses and allied health personnel will be reaching retirement age very soon and there are no graduates being trained and prepared to meet the demands of present and future health services. However, health training institutions have started functioning again in different zones. Recently, two medical schools were opened in Mogadishu and Amoud in the north-west. Transmission of the wild poliovirus has been interrupted in Somalia. In the year 2003, five rounds of house-to-house national immunization were conducted. In each round, an average of more than one million children were immunized and vitamin A was distributed. Acute flaccid paralysis surveillance was expanded to cover all regions with performance indicators surpassing the transmission. All this was achieved through the development of an extended human and logistic infrastructure. The collaboration between the Ministry of Health, UNICEF and WHO in this regard is unique and eventually resulted in the eradication of poliomyelitis from Somalia.

In conclusion, I would like to appeal to the international community through this esteemed Health Assembly to assist Somalia in its health projects in order to overcome the present difficulties in the implementation of the basic health projects for a nation that is slowly emerging from a civil war which has been raging for the past decade.

The PRESIDENT:

Thank you very much the honourable delegate of Somalia. As in so many countries, again conflict has destroyed the health system. In your country women and children are the biggest victims, hence your earnest desire for peace. Your request for help is also noted.

Dr ARAFAT (Palestine): الدكتور فتحي عرفات (فلسطين):

السيد الرئيس، محمد ناصر خان، أصحاب السعادة، السيدات والسادة، أود أن أهنئكم سيدي الرئيس على انتخابكم رئيساً لهذه الجمعية وزملاءكم الكرام. إنني على ثقة من أنكم بحكمتكم ستقودون أعمال هذه الدورة بنجاح.

كما أنني أود أن أشكر السيد المدير العام الدكتور جونغ - ووك لي لما يقدمه لمساعدة شعبنا الفلسطيني. ولا يفوتني أن أتقدم بالشكر إلى الدكتور حسين الجزائري لكل الجهود التي بذلها من أجل مساعدة شعبنا.

سيدي الرئيس، منذ ثلاثين عاما وأنا أقف على هذا المنبر وأعلن لكل ممثلي دول العالم أنه مادام هناك احتلال فإن شعبنا الفلسطيني لن يستطيع أن يتمتع بهدف منظمتكم الموقرة المتمثل في توفير "الصحة للجميع بحلول عام ٢٠٠٠". وها نحن ندخل في السنة الرابعة للقرن الحادي والعشرين ومازال شعبنا يعاني من ويلات هذا الاحتلال الذي هو السبب الرئيسي في اعتلال صحته.

إن هذا التدهور، على كافة الأصعدة الصحية والاقتصادية والاجتماعية، الذي نراه جميعاً يحيق بشعبنا، ما كان له أن يكون لولا هذا الاحتلال الذي مازال يواصل إجراءاته القمعية وممارساته الوحشية ضد أبناء شعبنا الفلسطيني التي كان آخرها هدم أكثر من مائتي منزلٍ خلال الأسبوع الماضي فقط في مدينة رفح ومخيمها. مضيفاً بذلك مئات آخرين لستة عشر ألف فلسطيني مشّردين من الذين هُدمت منازلهم منذ بداية الانتفاضة في أيلول/ سبتمبر عام ٢٠٠٠ في كل مدن وقرى فلسطين. ومازالت المنطقة في رفح مغلقة وتتعرض للمزيد من هدم البيوت وقتل وجرح المئات. وقد جاءني الآن أن مظاهرة سلمية، تنقل الغذاء والماء إلى شعبنا المحاصر في تل السلطان في رفح، قصفت بالصواريخ ونتج عن هذا الاعتداء ٢٣ شهيداً وأكثر من مائة جريح بالإضافة إلى مواصلة قوات الاحتلال الإسرائيلي حملات الاعتقال شبه اليومي التي طالت الآلاف من المواطنين الفلسطينيين بمن فيهم الأطفال والنساء.

السيد الرئيس، لقد سجلت أقسام الطوارئ في مستشفياتنا على مدار الأربع سنوات أكثر من خمسين ألف جريح واستشهاد ما يزيد على الثلاثة آلاف، بلغت نسبة الأطفال دون سن الثامنة عشرة ٢٢٪ وبلغ عدد الأطفال الرضّع ١٧ ومن هم دون السادسة عشرة ثمانية وخمسين شهيداً. إن ثلث هذا العدد من الأطفال قد استشهدوا نتيجة لمنع قوات الاحتلال سيارات الإسعاف التي تقلهم من المرور على الحواجز العسكرية بينما استشهد ربع هذا العدد نتيجة استهدافهم برصاص حي. أما سياسة الاغتيالات والتصفية الجسدية التي حرّمتها كل المواثيق والأعراف الدولية فقد بلغ عدد ضحاياها أكثر من أربعمائة وخمسين شهيداً.

السيد الرئيس، إن بناء جدار الفصل العنصري أو ما تطلق عليه إسرائيل بالحاجز الأمني قد ميز الأعمال التعسفية الإسرائيلية هذا العام إذ تم بناء ما يزيد على ١٦٥ كيلومتراً من أصل ٦٥٠ كيلومتراً على الأراضي الفلسطينية المحتلة الأمر الذي سيؤدي إلى قضم حوالي ٥٠٪ من أراضي الضفة وهو ما سيؤدي بالتالي إلى عزل عدد كبير من قرانا عزلاً كاملاً وعزل عدد آخر أكبر من هذه القرى عن أراضيها الزراعية. وقد أظهرت الإحصائيات بأن اكتمال بناء هذا الجدار سيؤدي إلى عزل أكثر من نصف مليون فلسطيني وحرمانهم من الوصول إلى المرافق الأساسية، خاصة الصحية والتعليمية.

السيد الرئيس، لقد أدت سياسة الإغلاق ومنع التجوال التي تنتهجها حكومة إسرائيل ضد شعبنا إلى ارتفاع غير مسبوق في البطالة وإلى ارتفاع معدل فقر الدم، بلغت نسبته ٦٤،٩٪ حسب إحصائيات البنك الدولي، الأمر الذي أدى إلى سوء التغذية الحاد لدى الأطفال بنسبة ١٠٪؛ فقر الدم بين الأطفال دون الخامسة بنسبة ٤٤٪؛ فقر الدم بين السيدات في غزة بنسبة ٥٢٪ وفي الضفة بنسبة ٤٣٪. كل ذلك إضافة إلى ما أدت إليه نتائج الممارسات الإسرائيلية ضد القطاع الصحي سواء بالاعتداء على الطواقم الطبية، حيث استشهد ثلاثون منهم وجرح ٤٢٨ إضافة إلى اقتحام المستشفيات كما تم تدمير أكثر من ثلاثين من سيارات الإسعاف.

السيد الرئيس، لا أستطيع أن أخفي قلقنا المتزايد جراء الانقطاع في برامجنا التطعيمية، وذلك بسبب الإغلاقات المستمرة وانقطاع التيار الكهربائي وتأثيره السلبي على التبريد الأمر الذي قلل حيوية ونجاعة التطعيمات التي نقدمها لأطفالنا.

وأخيراً، فإني أود أن ألفت انتباهكم جميعاً إلى ما نخشاه أيضاً من الانعكاسات السلبية للممارسات الاحتلالية على صحة شعبنا النفسية، خاصة على أطفالنا الذين تتراوح إصاباتهم بين صدمات نفسية، إلى شعور بعدم الأمان، وانتشار أعراض سلوكيات الصدمة بين الأطفال التي تتراوح بين الكوابيس والتبول اللاإرادي، إلى العدوانية الزائدة إضافة إلى انخفاض مستوى الانتباه والقدرة على التركيز.

السيد الرئيس، بالرغم من كل ما ذكرت من مآس يتعرض لها شعبنا الفلسطيني على مدار سنين طويلة، فإن شعبنا الفلسطيني لم يفقد الأمل بعد في أن دول العالم لن تقبل استمرار هذا الظلم عليه، فهو يثق بأن دولكم الموقرة سوف تعمل كل ما في وسعها ليس فقط من أجل رفع هذه المعاناة بل من أجل إنهاء الاحتلال، وهو سبب كل هذه المعاناة، لإحلال السلام العادل والشامل ليعيش في ظله أطفالنا الفلسطينيون والأطفال الإسرائيليون وكل أطفال العالم في أمن وسلام.

شكراً سيدي الرئيس.

The PRESIDENT:

Thank you, the representative of Palestine. Yet another country devastated by war, where the health systems have been destroyed and the country destroyed. Again, the victims are the babies, the children, the women and the civilian population. You report that innocent people's homes are being destroyed and people injured. Your request for help, especially in the health sector and to save your children, is noted.

Dr MORINIÈRE (International Federation of Red Cross and Red Crescent Societies):

On behalf of the International Federation of Red Cross and Red Crescent Societies and on behalf of our Director for Health, Dr Eshaya-Chauvin, who was unable to attend today, we welcome the opportunity to address this Health Assembly, and to pledge our support for reducing global mortality from major preventable diseases. An estimated 13 million preventable deaths continue to occur each year and most of these deaths are children in developing countries. International donors, technical agencies, and other interested parties such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, Roll Back Malaria, the Global Alliance for Vaccines and Immunization (GAVI) and others, are working to increase funding to combat these diseases. Yet achieving high coverage rates, ensuring access for the most vulnerable, and ensuring equity among the poorest who cannot pay for services are still challenges facing us. While we are increasing the supply side of disease control and strengthening service delivery mechanisms, more attention to the demand side of control programmes is needed. Communities and individuals must know about, want, and seek needed services on a routine, ongoing and sustainable basis.

The Red Cross and Red Crescent national societies throughout the world, all of which serve as auxiliaries to government and public authorities, are an integral part of the affected communities. As important members of civil society, our volunteers everywhere are working hard to reach the most vulnerable to ensure access and equity. Community networking, social mobilization, and education for behaviour change are the hallmarks of our Red Cross and Red Crescent national societies. In 2000, the International Federation pledged to this Health Assembly that it would increase its civil society responsibility by more aggressively advocating for the most vulnerable through innovative partnerships. We are indeed happy to provide an interim report on what we have achieved. It is our hope that the work of the International Federation and national Red Cross and Red Crescent societies will be seen by this Health Assembly and other parts of the international system as a direct contribution to the work that all organizations must do if the Millennium Development Goals are to be fulfilled.

Building on our comparative advantages as an organization with the closest of links to civil society, Red Cross and Red Crescent societies at global and national levels are joining in alliances such as national AIDS committees, country coordinating mechanisms, interagency coordinating committees, and the Child Survival Collaboration and Resources Group, a coalition of more than 37 nongovernmental organizations supporting Roll Back Malaria efforts. Partnerships to reduce vulnerability to HIV/AIDS and the other infectious diseases such as tuberculosis, malaria, measles and poliomyelitis have been created and are growing rapidly. We have been honoured to serve on the GAVI and the Global Fund boards as representative of international organizations. More and more of our national societies are joining with national Global Network of People Living with HIV/AIDS groups to address HIV/AIDS. Since January 2003, the Federation has made more than 4 million Swiss francs available, largely to support poliomyelitis eradication in WHO's highest-priority countries and to supplement measles social mobilization activities in countries where the Measles Partnership is implementing supplemental immunization activities. This major Partnership, with financial support from the American Red Cross, the Centers for Disease Control and Prevention, and the United Nations Foundation, is working closely with ministries of health, WHO, UNICEF, the Federation and many other partners. To date, more than 125 million African children have been vaccinated in 25 countries, with Red Cross and Red Crescent societies mobilizing more than 50 000 volunteers for social mobilization, logistics, and follow-up activities. The Partnership aims to reach 200 million children by 2005 and preventing several hundred thousand measles deaths annually. Success in this partnership effort has generated interest in expanding the measles immunization platform and logistics to provide vitamin A, mebendazole, and insecticide-treated bednets (ITNs) in an integrated fashion. In 2002, a pilot effort to distribute free ITNs in one remote and underserved district in Ghana resulted in more than 80% coverage of households. In an expanded effort in 2003, in five remote districts in Zambia, more than 80 000 ITNs were distributed using the measles supplemental immunization platform. Again, more than 80% of households were covered and the Abuja targets for children under five years of age and pregnant women sleeping under ITNs were achieved in six days. A nationwide ITN coverage effort in Togo later this year is now in the planning phase. More than

730 000 free ITNs will be distributed with intensive community education, social mobilization, follow-up and evaluation provided by more than 15 partners. Successful implementation will ensure that Togo achieves its Abuja targets for ITN coverage within a nine-day effort in December. We look forward to reporting to the Health Assembly in 2005 on the disease impact of this scaled-up public health intervention.

We congratulate WHO and UNICEF on a joint statement endorsing the approach we have been piloting. The February 2004 statement entitled "Malaria control and immunization: a sound partnership with great potential" is innovative and has the potential to lead to the scaled-up efforts that donors, international agencies and technical agencies are seeking. The International Federation welcomes and supports this policy development. We look forward to working with WHO, governments and other partners to implement the WHO/UNICEF comprehensive strategies for measles mortality reduction and for scaling-up malaria control activities. National Red Cross and Red Crescent societies and their volunteers will work with you towards increasing the demand for these interventions. We support the call for strengthening partnership at the global, regional and national levels. As an international organization with a bridging role, we believe that a broader involvement of nongovernmental organizations is the way forward. The successful mobilization of civil society and the active involvement of community volunteers are essential for sustainable public health interventions. In this way, donors, technical agencies and civil society will see improvements in the health of the most vulnerable populations and achieve the desired progress towards the fulfilment of the Millennium Development Goals.

The PRESIDENT:

Thank you, honourable representative of the International Federation of Red Cross and Red Crescent Societies. We all compliment you for serving humanity all over the world in difficult countries with disease, conflicts, natural disasters and providing health care to the desperate populations of the world.

Monseñor LOZANO-BARRAGÁN (Santa Sede):

Señor Presidente, señor Director General de la Organización Mundial de la Salud, Dr. LEE Jong-wook, distinguidos ministros, honorables delegados, señoras y señores: Señor Presidente, lo saludo atentamente y lo felicito por la acertada dirección de la presente Asamblea.

Desde la aparición de la pandemia, ha sido siempre preocupación de la Santa Sede empeñarse a fondo en la lucha contra el SIDA. Lo hace en los 113 257 centros de salud gestionados por católicos en todo el mundo y en sus 5393 hospitales, especialmente en los países en vías de desarrollo. De hecho, como es ya sabido, de cada cuatro centros de atención de enfermos de SIDA, uno lo atiende la Iglesia Católica. Hemos estado siempre abiertos a la cooperación oportuna con los centros internacionales de lucha contra el SIDA, en todo lo que juzgamos efectivo.

Como una aportación más a esta colaboración me complace presentar como una anticipación, el Manual para la atención pastoral de los enfermos de SIDA, elaborado en mi Consejo, y que ahora se encuentra en su fase final, pues ya confeccionado, están ahora trabajando nuestros equipos técnicos en su presentación en DVD, en VHS y en libro gráfico. Esperamos que esté terminado para Navidad y poder ponerlo a disposición, especialmente de la OMS y el ONUSIDA, a principios del próximo año. Quisiera este Manual ser un esfuerzo de parte de la Santa Sede para sumarnos de una manera particular, a la tan laudable campaña «tres millones para 2005» de la OMS en la lucha mundial contra el SIDA. El Manual consta de seis capítulos, en los que hablamos del pensamiento de Juan Pablo II sobre el SIDA, de la naturaleza de la pandemia; su estado en el mundo, su historia, su transmisión; nociones sobre la estructura del virus; los centros contra el SIDA a cargo de la Iglesia Católica; continentes, países y acciones mediante las cuales lleva a cabo esta lucha la Iglesia; subrayamos la que hemos llamado «Operación Navidad», en la que tratamos de crear un padrinazgo entre 46 países de dentro de África y de fuera de África, confiando a estos últimos la ayuda para las necesidades más urgentes en la lucha africana contra esta enfermedad. Luego pasamos a reflexionar sobre las causas y condiciones de la enfermedad, hablando en el ámbito de la cultura del pansexualismo, de la revolución

sexual, de la pobreza, de la urbanización, del tejido social, del estigma, y de los contextos políticos. Damos un lugar de primera importancia a la prevención, insistiendo en la educación, en el contenido de la misma y a quiénes deba dirigirse; un lugar especial damos a la prevención higiénica. En el rubro del acompañamiento al enfermo de SIDA, destacamos la importancia de tomar conciencia de la enfermedad y seguir distinta y atentamente todas sus fases, incluida la etapa terminal, hablamos del comportamiento que deban tener los padres y en general la familia del paciente hacia el enfermo de SIDA, de qué deban hacer los obispos y los sacerdotes, los capellanes y equipos, los médicos y demás profesionales de la salud, los voluntarios y las conferencias episcopales.

Nuestro Manual lo publicaremos en español, inglés, francés e italiano, y daremos las facilidades necesarias para que si así se desea, se pueda traducir a otras lenguas Hace dos años, conectado con este Manual de SIDA, publicamos otro manual sobre el cuidado pastoral del drogadicto, que a Dios gracias ha tenido muy buena aceptación en el mundo. Ha sido traducido, además de a las lenguas citadas, al portugués, al polaco, al lituano; y lo hemos puesto a disposición del Programa de las Naciones Unidas para la Fiscalización Internacional de Drogas, con sede en Viena, ya que precisamente dicha oficina hace tiempo que nos lo solicitó.

Seguiremos en adelante colaborando con la OMS en todos sus laudables esfuerzos por lograr una mejor salud para todos.

The PRESIDENT:

Thank you very much, the representative of the Holy See. May we compliment you on the wonderful work you are doing with Third World countries and hundreds of health care outlets to serve ailing humanity.

Dr MARIA DE ARAUJO (Timor-Leste):[1]

Timor-Leste became a member of WHO in 2002 and was assigned to WHO's South-East Asia Region by the Fifty-sixth World Health Assembly in May 2003. We are the youngest member of WHO and are proud to be a part of the South-East Asia Region.

Timor-Leste is one of the least developed countries in the world with low levels of education and poor health services delivery. The country has many health problems similar to those of low-income countries such as high infant and child mortality mainly due to infectious diseases and malnutrition, and poor prenatal and obstetrical services; and high prevalence of infectious diseases such as tuberculosis, malaria and leprosy. As a newly independent country with limited resources there are definitely shortages of well-trained health staff at all levels. The Government of Timor-Leste is committed to ensuring delivery of affordable and cost-effective preventive and curative health services to the community through the primary health care approach. Nonetheless, Timor-Leste has given its highest commitment to health and education development. The Ministry of Health is pushing hard to establish and develop its health system, emphasizing quality and access with the support of many international partners, including WHO. WHO is supporting the country to further its health development and improve the health status of its population. Not only does it consider the health situation in the country and the capacity of the Ministry of Health but it also looks at the roles of other key partners in determining how WHO should direct its resources to maximize benefits to the country.

WHO has been present in Timor-Leste since September 1999 and provides support to the Ministry of Health in implementing priority activities for the improvement of the current health situation in the country. WHO's presence in Timor-Leste has already had a substantially positive effect on the health situation in the country.

WHO has been instrumental in providing technical guidance to the country coordination mechanism in applying for funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. I am pleased to inform you that the country has received funds for malaria and tuberculosis control.

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[1] The text that follows was submitted by the delegation of Timor-Leste for inclusion in the verbatim records in accordance with resolution WHA20.2.

The main challenges to be addressed by the health sector remain the high rates of maternal and infant mortality; high mortality and morbidity due to communicable diseases; prevalence of malnutrition, iodine and vitamin A deficiency; lack of access to safe drinking-water, sanitary facilities and proper shelter for a majority of the population; poor knowledge on health matters among the general population; and poor and inadequate access to health services.

I strongly support the country focus initiative taken by the Director-General to bring resources and provide staff to the countries. I am sure shifting resources to the countries will serve the countries more effectively and I am optimistic that donors will support this WHO initiative.

The Democratic Republic of Timor-Leste recognizes the valuable contributions made by WHO in its efforts to build the health sector and health system in order to provide basic health care facilities to its people. We look forward to continuing our close partnership with WHO to tackle the health problems being faced by the youngest country in the WHO family. At this stage, Timor-Leste requires more resources and support to achieve improved health status for its people. I am sure WHO will give extra care and attention to this new-born democracy. I would also like to assure all Member countries of WHO that Timor-Leste will always try to do its best in addressing health needs, particularly amongst the most vulnerable populations.

Mrs POSTOYALKO (Belarus):[1]
Г-жа ПОСТОЯЛКО (БЕЛАРУСЬ):[1]

Уважаемый г-н Председатель, уважаемый г-н Генеральный директор, уважаемые дамы и господа.

Прежде всего позвольте мне выразить уверенность, что работа нашего форума будет плодотворной и окажет позитивное воздействие на дальнейшее развитие мирового здравоохранения.

Уважаемые делегаты.

Мы с большим вниманием выслушали доклад Генерального директора и высоко оцениваем работу по его подготовке. Отмеченная в докладе ситуация по эпидемии ВИЧ/СПИДа справедливо вызывает озабоченность во всех странах мира. Беларусь приветствует мобилизацию всех политических и финансовых ресурсов для ответных действий по эпидемии на глобальном, региональном и страновом уровнях и поддерживает Декларацию о приверженности делу борьбы с ВИЧ/СПИДом и Глобальную стратегию сектора здравоохранения по ВИЧ/СПИДу Всемирной организации здравоохранения. Мы также рассматриваем обеспечение антиретровирусной терапией в качестве ключевого момента в эффективной борьбе с эпидемией наряду с профилактикой и лечением оппортунистических инфекций. В этом плане большое значение будет иметь поддержка Глобального фонда для борьбы против СПИДа, туберкулеза и малярии, успешная реализация инициативы "3 к 5".

В Республике Беларусь за период статистического наблюдения (с 1987 г.) выявлено 5678 ВИЧ-инфицированных лиц, что составляет 57,6 на 100 000 населения. По оценочным данным, реальное число инфицированных составляет 11 000-15 000 человек. Наиболее пораженной частью населения является молодежь в возрасте от 15 до 29 лет (80,6% от общего числа ВИЧ-инфицированных). Основной путь передачи ВИЧ - парентеральный, реализуемый через инъекционное введение наркотических средств (37,2%). От ВИЧ-инфицированных матерей родилось 444 ребенка, 25 из которых поставлен диагноз "ВИЧ-инфекция". ВИЧ-инфекция перешла в стадию СПИДа у 101 пациента. Ожидается, что к 2005 г. количество больных СПИДом в Республике достигнет 500-700 человек. Дальнейшему распространению ВИЧ-инфекции способствует напряженная ситуация по инфекциям, передающимся половым путем, и нарастающая эпидемия наркомании.

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[1] The text that follows was submitted by the delegation of Belarus for inclusion in the verbatim records in accordance with resolution WHA20.2.

[1] Данный текст представлен делегацией Беларусь в соответствии с резолюцией WHA20.2 для включения в стенограммы выступлений.

В связи со сложившейся ситуацией в Беларуси принимаются активные меры по обеспечению медицинской и социальной помощью ВИЧ-инфицированных и больных СПИДом. Указанным пациентам доступны все виды необходимой медицинской помощи, как и всем гражданам Республики.

Во всех областных городах открыты специализированные диспансерные кабинеты, работающие при инфекционных больницах, в которых проводится консультационная деятельность, диспансеризация и антиретровирусная терапия. В Республике Беларусь используется клиническая классификация, разработанная в строгом соответствии с рекомендациями ВОЗ. На основании этих рекомендаций проводится выбор больных для проведения эффективной трехкомпонентной антиретровирусной терапии, причем используется только данный вид терапии в связи с опасностью развития устойчивости к антиретровирусным препаратам. Особое внимание уделяется также вопросам оказания медицинской помощи соответствующему контингенту нуждающихся в петенциарной системе, наркоманам и наркопотребителям.

Следует отметить, что в Беларуси осуществляется целенаправленная работа, в том числе и научно-исследовательская, по созданию новых более дешевых лекарственных форм и апробации альтернативных схем лечения (разработан препарат зальцитобин, еще один противовирусный препарат находится в стадии клинических испытаний). Эта работа чрезвычайно важна для обеспечения нуждающихся пациентов более дешевой, рациональной и максимально доступной терапией. Проводятся также исследования по определению иммунного статуса больных, вирусной нагрузки, необходимой для объективного контроля за терапией.

Хотелось бы также сообщить, что людям, живущим с ВИЧ/СПИДом, как и всем гражданам Республики Беларусь, гарантированы все права, предусмотренные Конституцией, запрещена любая дискриминация, соблюдены принципы конфиденциальности. Отсутствуют формальные и реальные ограничения в праве получения любых видов консультативной, лечебной, а также высококвалифицированной хирургической помощи. В соответствии с методическими указаниями 2003 г., выстроена этапная система оказания помощи ВИЧ-инфицированным и больным СПИДом. При отделах профилактики СПИДа, а также в учреждениях пенитенциарной системы существуют центры социальной и психологической поддержки, имеющие большой опыт работы и оказывающие значительную практическую помощь. Наркопотребителям и заключенным антиретровирусная терапия доступна при наличии таких же клинических показателей, как и другим пациентам.

В целом Республика Беларусь обладает достаточным числом высококвалифицированных специалистов по вопросам ВИЧ/СПИДа и медицинских учреждений, оказывающих помощь ВИЧ-инфицированным и больным СПИДом. Стационарная помощь незамедлительно предоставляется для всех нуждающихся. Антиретровирусная терапия проводится для пациентов бесплатно за счет государственного бюджета. Вместе с тем, высокая стоимость лекарственных средств, безусловно, является актуальной проблемой, влияющей на расширение показаний к назначению высокоактивной многокомпонентной антиретровирусной терапии и требующей выделения значительных средств из бюджета на здравоохранение.

В этой связи мы надеемся на получение помощи из Глобального фонда для борьбы против со СПИДа, туберкулеза и малярии, куда Республикой представлены заявки на осуществление проектов по борьбе с ВИЧ/СПИДом и туберкулезом, а также на участие в реализации инициативы "3 к 5".

Пользуясь случаем, хотела бы выразить большую признательность ВОЗ и ЮНЭЙДС за значительную помощь в подготовке необходимых заявок.

Благодарю за внимание.

M. RI TCHEUL (République populaire démocratique de Corée) :[1]

Monsieur le Président, Mesdames et Messieurs, au nom de la délégation de la République populaire démocratique de Corée, je voudrais tout d'abord vous féliciter, Monsieur le Président, pour votre élection à la présidence de cette Assemblée. Mes félicitations vont également à Monsieur le Directeur général pour avoir présenté le rapport bien structuré qui donne à la fois une vue d'ensemble de la situation de la santé publique dans le monde et des propositions précises pour relever les défis qu'elle rencontre.

Il est à noter que la guerre et la terreur, le chômage et la pauvreté, l'alcoolisme et les toxicomanies, le SIDA et d'autres épidémies, l'inéquité dans le domaine économique et social continuent à se propager dans le monde en remettant en cause le développement et la promotion de santé de l'humanité. En particulier, le SIDA, thème majeur de cette Assemblée, est le plus grave problème de santé publique des temps modernes et la riposte mondiale à l'épidémie figure parmi les préoccupations prioritaires de l'OMS en raison de ses effets destructifs sur la santé et la vie quotidienne de la population. La gravité de la situation est largement reconnue : 40 millions de personnes dans le monde vivent avec le VIH, la majorité d'entre elles n'ont pas accès à la thérapie antirétrovirale, et trois millions sont décédées dans la seule année 2003. A moins que des mesures efficaces de soins et de prévention ne soient très rapidement prises, le SIDA infligera d'énormes pertes sur le plan humain et socio-économique aux générations présentes et futures. Pour faire face à ce fléau, la communauté internationale s'est engagée depuis la cinquante-cinquième session de l'Assemblée générale des Nations Unies, en adoptant la Déclaration du Millénaire, à avoir stoppé la propagation du VIH/SIDA et commencé à inverser la tendance actuelle d'ici 2015 et à promouvoir l'accès universel aux médicaments essentiels à des prix abordables, ce qui mérite notre appréciation. Nous nous félicitons tout particulièrement que l'OMS se soit engagée à aider les pays en développement à fournir un traitement anti-VIH à trois millions de personnes d'ici 2005, initiative à l'échelle mondiale dite « 3 millions d'ici 2005 ».

Monsieur le Président, la prévention active constitue un élément essentiel d'une riposte complète face à l'épidémie de VIH/SIDA ; c'est la leçon que la communauté internationale tire de la lutte contre cette épidémie depuis plusieurs années. Différents aspects de la prévention, à savoir éducation de la population, pratiques sexuelles à moindre risque, prévention de l'infection à VIH parmi les toxicomanes par voie intraveineuse, prévention de la transmission mère-enfant du VIH, sont des éléments clés de la prévention à long terme. La République populaire démocratique de Corée n'est pas touchée jusqu'ici par le SIDA, le syndrome respiratoire aigu sévère (SRAS) et la grippe aviaire, qui sont des problèmes sérieux dans une grande partie du monde ; cependant, elle prend toutes les mesures possibles à l'échelle nationale pour prévenir ces épidémies.

Permettez-moi, Monsieur le Président, de profiter de cette opportunité pour vous présenter en bref les activités récentes menées par le Gouvernement de la République populaire démocratique de Corée. Le Gouvernement, partant de l'idée de son grand leader, le Général KIM JONG Il, selon laquelle l'homme se trouve au centre de tout, maintient la promotion constante du bien-être du peuple comme étant le principe directeur de ses activités. En dépit de quelques difficultés engendrées par les calamités naturelles successives et l'environnement politique, il continue à appliquer sa politique populaire, telle que le système de soins médicaux gratuits et le système de l'enseignement supérieur gratuit. Les établissements sanitaires et pharmaceutiques existants sont en voie de réhabilitation, et une attention particulière est accordée à la promotion de l'efficacité du système de soins médicaux gratuits et du système de surveillance médicale par unité administrative. Nous menons également la lutte contre certaines maladies infectieuses avec la collaboration étroite des organisations internationales dont l'OMS. La stratégie DOTS, mise en place depuis 1998, couvrait les deux tiers du territoire en janvier 2003 et tout le pays à la fin de 2003. Quant au paludisme, réapparu ces dernières années dans mon pays, nous luttons pour atteindre fin 2005 l'objectif d'éradication complète. La poliomyélite est entièrement éradiquée grâce à la vaccination des enfants de moins de cinq ans, qui a eu lieu deux fois

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[1] Le texte qui suit a été remis par la délégation de la République populaire démocratique de Corée pour insertion dans le compte rendu, conformément à la résolution WHA20.2.

par an en octobre et en novembre depuis 1999 à l'occasion de la campagne nationale de vaccination. Et en avril 2003, suite à la consultation conjointe du Ministère de la Santé publique de la République populaire démocratique de Corée, de l'OMS, d'organisations du système des Nations Unies, d'organisations internationales de développement et d'organisations non gouvernementales, a été adoptée la stratégie commune de coopération de l'OMS pour la République populaire démocratique de Corée.

Pour terminer, je voudrais vous réaffirmer que le Gouvernement de la République populaire démocratique de Corée continuera à renforcer la collaboration avec l'OMS pour promouvoir la santé publique dans le pays et le monde ; je souhaite encore une fois plein succès à l'Assemblée grâce à la contribution de tous les participants ici présents.

Dr PARIRENYATWA (Zimbabwe):[1]

My delegation fully supports the statement read by the Minister of Health and Quality of Life of Mauritius on behalf of the Southern African Development Community.

Zimbabwe is one of the countries worst affected by HIV/AIDS, and indeed our region is at the epicentre of this pandemic. We estimate that 1.82 million Zimbabweans are infected and of these, approximately 340 000 are in urgent need of antiretroviral therapy. While prevention remains the mainstay of our response, recently we have stepped up our efforts to fight the poverty, stigma and discrimination associated with HIV/AIDS, as well as to improve access to antiretroviral therapy. Our efforts to fight poverty are being complemented by improving access to land for enhanced agricultural production for our citizens. This should result in better nutrition, leading to improvement in the general health and well-being of our population. Simultaneously we are upgrading health systems and human resources for health to achieve our treatment and care objectives. Our target for the "3 by 5" initiative is about 170 000. However, to date, only 5000 people living with HIV/AIDS are on treatment.

Zimbabwe has established a National AIDS Trust Fund, which has so far raised the equivalent of more than US$ 15 million, of which US$ 3 million are earmarked for antiretroviral therapy. In addition the Government has provided US$ 4 million. Unfortunately, this total of US$ 7 million is only able to sustain treatment for 10 000 people living with HIV/AIDS. We therefore welcome the global efforts by WHO and partners to improve access to treatment through significant reduction in antiretroviral prices, higher levels of international financing, strengthened training and technical support to countries.

Substantial financial resources have been mobilized globally through the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank Multi-Country HIV/AIDS Programme, the President's Emergency Plan for AIDS Relief, the Clinton and the Bill & Melinda Gates Foundations and others. However, we note with particular concern that the disbursements of approved grants to countries from the Global Fund have been very slow and the distribution of some of the funds from the various initiatives has been politicized to the detriment of people living with HIV/AIDS.

The health delivery systems in developing countries are overstretched by a high disease burden: HIV/AIDS and the high attrition of health personnel have worsened this situation. We call upon this Fifty-seventh World Health Assembly to seriously discuss and come up with solutions that address the continued brain drain from developing nations. In Zimbabwe this brain drain, estimated at 68%, has compromised our ability to rapidly scale up our efforts to provide comprehensive and quality HIV/AIDS services.

Despite these challenges, Zimbabwe will endeavour to continue meeting its obligation to prevent new infections while providing treatment and care to people living with HIV/AIDS. Recent estimates by the Ministry of Health and Child Welfare, UNAIDS, Imperial College London and Centers for Disease Control and Prevention, indicate that our HIV prevalence among adults aged 15-49 has "plateaued" around 24.6% and is beginning to show signs of a decline.

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[1] The text that follows was submitted by the delegation of Zimbabwe for inclusion in the verbatim records in accordance with resolution WHA20.2.

Tuberculosis remains a major problem due to increasing HIV co-infection rates: our current prevalence estimates indicate a 10-fold increase (from 44 to 485 per 100 000) in the past 10 years. In response to this growing problem we continue to strengthen the provision of directly observed treatment, short course, (DOTS) management of HIV/AIDS opportunistic infections, including co-infection with tuberculosis. We have managed to keep multidrug-resistant tuberculosis to insignificant levels of less than 1%.

Malaria still remains a major public health problem in our region. While the launch of the Roll Back Malaria initiative in 1998 provided hope for halving the malaria burden by 2010, with less than six years remaining, most countries in our region are lagging behind the annual targets. To accelerate the attainment of the African Summit targets by 2005, we will need to redouble our efforts and we call for more international support and partnerships. In this respect we call upon the Global Fund, through its Local Fund Agent, to be more sensitive to our urgent needs and simplify its processes for the release of funds.

Zimbabwe views health as a fundamental human right and an entry point to development. In this regard our Government is committed to improving access to health for all its citizens. With our commitment, international partnership and support we can achieve the Millennium Development Goals, "3 by 5" and other targets that we have set ourselves to make the world a peaceful and healthier place to live in.

Mr LEVY (Israel):

I regret that I am compelled to ask for the right of reply as the Palestinian representative dedicated an entire speech to a political tirade in what is supposed to be a professional gathering. If there is at all a place for such a political statement, it is tomorrow in Committee B. The debate there itself will be singling out one country and one problem in comparison to problems worldwide. What is the reason for the violence that brought about the suffering which the distinguished delegate described? It is a conscious decision by the Palestinian Authority to engage in violence against Israel for political reasons. As a result, not only Palestinians suffer, but Israelis too: suicide bombings, a thousand casualties, thousands of injured, psychological damage to young and old. Medical crews on the Israeli side have been hit. In fact, the standing order for the suicide bombers is to work in teams: the first to kill as many passers-by as possible; the second to wait for the arrival of the medical teams and then to detonate themselves.

If Israel is constructing a fence, it is a defensive fence against suicide bombers. It is not a political fence, it is reversible if conditions change. If Israel is compelled to take action in Rafah it is because tunnels are being dug there under the fence, to smuggle rockets and explosives for use in suicide missions against innocent Israeli civilians. Had the Palestinian Authority, which the distinguished Palestinian delegate represents, lived up to its solemn obligations to fight terrorism and incitement, there would be no need for a fence and no need for such operations in Gaza.

In conclusion, Mr President, the Palestinian representative talked about difficulties in immunization. We are concerned about it, too, and I would like to appeal through you to the Palestinian delegation here to renew professional medical cooperation with Israel. Rather than engaging in politics and debates, let us pick up the difficulties, let us work together; with WHO, perhaps, facilitating this kind of medical cooperation.

The meeting rose at 18 :15.
La séance est levée à 18h15.

SIXTH PLENARY MEETING

Thursday, 20 May 2004, at 17:00

President: Mr Muhammad Nasir KHAN (Pakistan)

SIXIEME SEANCE PLENIERE

Jeudi 20 mai 2004, 17 heures

Président: M. Muhammad Nasir KHAN (Pakistan)

AWARDS
DISTINCTIONS

The PRESIDENT:

The Health Assembly is called to order. We shall now proceed with item 7, "Awards".

We are assembled here today for the presentation of prizes awarded by the United Arab Emirates Health Foundation and the Sasakawa Memorial Health Foundation.

I have much pleasure in welcoming among us the distinguished winners of these prestigious prizes. I am also very pleased to greet His Excellency Hamad Abdul Rahman Al-Madfaa, Minister of Health of the United Arab Emirates, representing the founder of the United Arab Emirates Health Foundation and Mr Yohei Sasakawa, President of The Nippon Foundation, representing the Sasakawa Memorial Health Foundation.

Presentation of the United Arab Emirates Health Foundation Prize
Remise du Prix de la Fondation des Emirats arabes unis pour la Santé

We shall start with the presentation of the United Arab Emirates Health Foundation Prize. The prize is awarded jointly to the Shaukat Khanum Memorial Cancer Hospital and Research Centre in Pakistan and Mrs Stella Lubayelea Obasanjo from Nigeria for their outstanding contribution to health development.

The Shaukat Khanum Memorial Cancer Hospital and Research Centre of Pakistan was inaugurated in 1994. It provides either free or extremely low-cost care to a large number of cancer patients and conducts seminars, symposia, workshops and campaigns with clinics, creating awareness about cancer. The Centre organizes training programmes for medical students, physicians and surgeons. It works with referring physicians to develop a network for diagnosing patients in the early stages of cancer, develops screening programmes and new therapies for cancer treatment, and conducts research into the causes of cancer in our environment. In these endeavours, it collaborates with other institutions both in the country and worldwide.

Mrs Obasanjo, First Lady of Nigeria, is the founder and chairperson of the Child Care Trust. This Trust, in collaboration with the United Nations Children's Fund, contributed to the realization of

the 2001 National Programme on Immunization, which aimed to reduce infant mortality and promote safe motherhood in Nigeria. In 2003 the First Lady launched the Nigerian National Birth Registration exercise and has led a project to improve the situation of orphans and vulnerable children in her country. The Trust has initiated programmes such as the Special Education Programme, the Computer Literacy Programme and the Programme on Vocation and Skills Acquisition Activities. It also led the campaign for the Nigerian Child Rights Bill. Further, Mrs Obasanjo drafted and initiated the process for the signing of the Nigeria Disability Law, which led to the formation of the National Disability Commission, an agency ensuring the healthy development of disabled individuals. She has done wonderful work for children and mothers in Nigeria.

Before giving the prizes to our distinguished laureates, I have pleasure in inviting Dr Hamad Abdul Rahman Al-Madfaa, representing the United Arab Emirates Health Foundation, to address the Health Assembly.

Dr AL-MADFAA (United Arab Emirates Health Foundation):

السيد حمد عبد الرحمن المدفع (الإمارات العربية المتحدة):

بسم الله الرحمن الرحيم،

سعادة رئيس جمعية الصحة العالمية، الدكتور جونغ - ووك لي مدير عام منظمة الصحة العالمية المحترم، حضرات الزملاء، السلام عليكم ورحمة الله وبركاته،

يشرفني أن أرحب بكم باسم مؤسسة الإمارات العربية المتحدة للصحة في هذا الاحتفال السنوي الذي تنظمه جمعية الصحة العالمية لتكريم الأطباء والعلماء والمؤسسات والشخصيات العالمية الأخرى التي أسهمت بعطاء وافر في إثراء العمل الصحي وتعزيز دور المنظمة الرائد في المحافظة على صحة وسلامة الإنسان. كما أغتنم هذه المناسبة لأتقدم بجزيل الشكر والامتنان للمجلس التنفيذي التابع للمنظمة للجهود الطيبة التي يبذلها جميع أعضائه في الإعداد لتكريم الفائزين بهذه الجائزة.

السيدات والسادة، لقد أنشئت مؤسسة الإمارات العربية المتحدة للصحة بمبادرة كريمة من صاحب السمو الشيخ زايد بن سلطان آل نهيان رئيس دولة الإمارات العربية المتحدة حفظه الله وتوجيه كريم من صاحب السمو الشيخ خليفة بن زايد آل نهيان ولي عهد أبو ظبي نائب القائد الأعلى للقوات المسلحة حفظه الله، فجاءت إضافة حقيقية لما حققته دولة الإمارات من إنجازات في القطاع الصحي طوال مسيرتها الوطنية التي امتدت إلى أكثر من ثلاثة عقود كما أنها تجسد إيمان واقتناع قيادتنا الرشيدة بالعمل الفاعل والنبيل لمنظمة الصحة العالمية لدورها الحيوي والبنّاء في حث العلماء والباحثين والأطباء الأجلاء على بذل المزيد من الجهد نحو خدمة الإنسان وحمايته من الأمراض والمحافظة على صحته وسلامته بجميع الوسائل المتاحة.

لقد تجلّت معالم هذه النهضة الصحية وتجسدت بوضوح حين التزمت دولة الإمارات ومنذ البداية على الاسترشاد بالمفهوم الشامل الذي يؤكد الارتباط الوثيق بين العوامل البيئية والاقتصادية والاجتماعية التي تؤثر سلباً أو إيجاباً على صحة الإنسان وسلامته. ومع الارتفاع السريع في عدد سكان دولة الإمارات الذي صاحب تطبيق البرامج التنموية الطموحة، واتساع مساحة المدن الرئيسية في الدولة وزيادة الوحدات السكنية وتوفير المياه العذبة النقية للسكان والإصحاح البيئي، كل ذلك استوجب مراجعة دقيقة ومتواصلة للقوانين البيئية لتنظيم عملية تطوير البنية التحتية لكافة هذه الخدمات في الدولة. ووزارة الصحة من جانبها بادرت باتخاذ خطوات إيجابية وفعالة نحو مراجعة استراتيجياتها الصحية من خلال تنفيذ دراسة وطنية تعتمد نظام الترصد التدرجي لتقييم عبء المراضة بقياس عوامل الاختطار المرتبطة بالأمراض المزمنة وكمدخل أساسي في برنامج إيمان لمكافحة الأمراض المزمنة. كما أن إصدار دليل السجل السرطاني الوطني للأعوام ١٩٩٨-٢٠٠٢ يعتبر مرجعاً رئيسياً لكافة المعلومات الخاصة بالأمراض السرطانية في الدولة وبمثابة جزء لا يتجزأ من استراتيجية الترصد الوبائي للأمراض المزمنة. كما أن استحداث الدليل الوطني للترصد الوبائي المبني على الأدلة والبراهين يأتي استجابة لمواجهة التحديات الصحية الجديدة والتي تتمثل في معاودة ظهور بعض الأمراض المعدية وأمراض مستجدة أخرى كالسارس وأنفلونزا الطيور والتي تحتاج إلى ترصد وبائي نشط لاكتشافها في أطوارها الأولى والحد من انتشارها.

وكان تبني دولة الإمارات لقرار منظمة الصحة العالمية حول الاتفاقية الإطارية بشأن مكافحة التبغ حافزاً على تفعيل برامج مكافحة التدخين في الدولة والتي تكللت بإعلان مونديال الشباب لكرة القدم الذي أقيم

على أرضها عام ٢٠٠٣ خالياً من التدخين، وجاء هذا الإعلان متفقاً مع توجه وزارة الصحة لاعتماد نظام المدارس المعززة للصحة في الدولة شراكة مع وزارة التربية والتعليم وداعياً لخلق المناخ المناسب في البيئة المدرسية لحث الطلاب على اكتساب سلوكيات وممارسات صحية سليمة.

السيدات والسادة، يشرفني، في هذا المقام، إعلام الحضور الكرام بأن مؤسسة الإمارات للصحة، وبموافقة المجلس التنفيذي لمنظمة الصحة العالمية، قررت منح جائزة هذا العام مناصفة إلى كل من السيدة ستيلا لوبايلي أبوسانجو، السيدة الأولى لجمهورية نيجيريا الاتحادية ومركز ومستشفى شوكت خانم التذكاري لأمراض وأبحاث السرطان في باكستان.

السيدة أبوسانجو مؤسسة ورئيسة صندوق رعاية الطفل في نيجيريا وذلك بالتعاون مع منظمة اليونيسيف لأجل تعزيز البرنامج الوطني للتحصين ومأمونية الحمل والولادة في نيجيريا بهدف خفض معدلات وفيات الأطفال الرضّع والأمهات. كما كان للسيدة الأولى أبوسانجو الفضل في إرساء نظام تسجيل المواليد في عام ٢٠٠٣ إلى جانب إنجازات عديدة أخرى، خاصة قيادتها لحملة المطالبة بحقوق الطفل التي تكللت بالتوقيع على قانون حقوق الطفل النيجيري في عام ٢٠٠٢ والقانون النيجيري لذوي الاحتياجات الخاصة.

أما مركز ومستشفى شوكت خانم التذكاري لأمراض وأبحاث السرطان في باكستان، الذي أسس في عام ١٩٩٤، فيوفر رعاية مجانية لمرضى السرطان إلى جانب تنظيم أنشطة مختلفة في لقاءات وورش عمل وغيرها للتوعية بهذا المرض. هذا ويقوم المركز أيضاً بتنظيم دورات تدريبية للأطباء بصورة منتظمة والمشاركة في تطوير شبكة متكاملة للتشخيص المبكر لأمراض السرطان والتي تمخضت عن تطبيق نظام جيد للمعلومات الإلكترونية يضاهي المستويات العالمية.

السيدات والسادة، إن دولة الإمارات، بإسهامها في منح جائزة الإمارات للصحة، تتطلع إلى حث العلماء والباحثين والمؤسسات العلمية والمنظمات والجمعيات ذات النفع العام في جميع أنحاء العالم على بذل المزيد من الجهد لمواكبة التطورات المتسارعة التي يشهدها عالمنا اليوم والتوصل إلى أساليب أكثر فعالية للتغلب على المشاكل الصحية التي كانت نتاجاً لها وأدت إلى معاناة كبيرة خاصة بين الدول الأقل حظاً في مواردها مما يشكل عبئاً إضافياً على تطورها وتنميتها.

وأخيراً لا يسعني إلا أن أتوجه لجمعكم الكريم هذا بالشكر والتقدير وبالتهنئة القلبية للفائزين بجائزة هذا العام. كما أؤكد مرة أخرى مواصلة سعينا في تقديم كل ما من شأنه أن يعود بالخير على البشرية جمعاء.

والسلام عليكم ورحمة الله وبركاته.

The PRESIDENT:

Before I invite the next distinguished guest, I just want to say a few things on a personal note. We are both from Pakistan, we both come from the same city, that is, Lahore. We are both elected members of Parliament in Pakistan and we are both Khans. And above all, he is my friend. He is a personality known all over the world and a cricket legend: one of the fastest bowlers of all times, with a tremendous batting record and foremost, he is a humane person and has built the finest cancer hospital in Pakistan. His passion to work for the poor is shown by this monument that is built in the name of his mother who died of cancer. It is now my privilege to present the United Arab Emirates Health Foundation Prize to the Shaukat Khanum Memorial Cancer Hospital and Research Centre represented by its founder, Mr Imran Khan.

Amid applause, the President handed the United Arab Emirates Health Foundation Prize to Mr Imran Khan.
Le Président remet le Prix de la Fondation des Emirats arabes unis pour la Santé à M. Imran Khan. (Applaudissements)

Mr KHAN:

Thank you very much, Mr President. You forgot to mention that, while you are in the Government, I am firmly in the Opposition. Also, to expect a politician to make a short speech is a contradiction in terms but I will try my best. Firstly, on behalf of the Shaukat Khanum Memorial Cancer Hospital and Research Centre, I would like to thank His Excellency, the Minister of Health of the United Arab Emirates, the United Arab Emirates Health Foundation and the WHO Executive Board for giving us the great honour of this award.

Very briefly, I was not really known to be a generous human being or a humane person. In 1985 my mother got cancer and she died a very painful death from that disease. It was while watching her suffer from cancer that I realized that in a country of 140 million people, we did not have a cancer hospital. That meant that the people with money could go abroad for treatment while the vast majority of people suffered, and families suffered with the cancer patients. So in 1985, the struggle to build the Cancer Hospital started. We went all over Pakistan to collect the funds and in December 1994, we opened the Hospital at a cost of US$ 25 million, all of it coming from donations from Pakistanis in the country and abroad. Since then, the Hospital has treated almost 40 000 cancer patients. Seventy-five per cent of all cancer treatment in our hospital is free which means that annually, the Hospital has a deficit of over US$ 7 million. The annual budget is US$ 14 million and the deficit is over US$ 7 million. This deficit we make up from collecting donations from Pakistanis within the country and Pakistanis abroad.

I am very proud to say that the Hospital is a centre of excellence. It has state-of-the-art facilities in chemotherapy and radiology, and for diagnosis. We are now starting research in our Hospital and, because there is a tremendous amount of pressure on the facility, since one cancer hospital cannot service the whole of the country, we are now in the process of building a second cancer hospital in Karachi.

I want again to thank the United Arab Emirates Health Foundation for giving us this award because it will give us credibility. For an institution that depends on credibility to collect these huge amounts of money, this award will go a long way in helping us in the future and, especially, in building the second cancer hospital in Karachi.

The PRESIDENT:

I now have great pleasure in presenting the United Arab Emirates Health Foundation Prize to Mrs Stella Lubayelea Obasanjo.

Amid applause, the President handed the United Arab Emirates Health Foundation Prize to Mrs Obasanjo.
Le Président remet le Prix de la Fondation des Emirats arabes unis pour la Santé à Mme Obasanjo. (Applaudissements)

Mrs OBASANJO:

I should like to begin this address by expressing my deepest appreciation to the United Arab Emirates Health Foundation Selection Panel and the Executive Board of the World Health Organization who, in their collective wisdom, selected me as co-winner of the United Arab Emirates Health Foundation Prize for 2004. This singular honour is the reason for the privilege that has entitled me to stand before this distinguished Health Assembly, to share my thoughts on child health, particularly the health and well-being of challenged children. Before I proceed further, I must extend my warm congratulations to the worthy co-winner of the United Arab Emirates Health Foundation

Prize for 2004, the renowned Shaukat Khanum Memorial Cancer Hospital and Research Centre, Pakistan.

I must say that I feel greatly humbled, but also encouraged, by the global recognition of my modest efforts to provide for the health care, social and emotional needs of physically and mentally challenged children in Nigeria. In choosing children as the focus of my activities, my guiding philosophy has been that children are a special gift from God, who need to be appreciated and loved, whatever their physical or mental circumstances. The Child Care Trust, a private, not-for-profit nongovernmental organization that I founded in 2000, is the vehicle through which I have sought to address the needs of underprivileged and challenged children in my country. The Child Care Trust is founded on the premise that an early intervention in the health, educational and emotional needs of challenged children could guarantee for them a happy, productive and self-sustainable adult life. This principle derives from my conviction that there is ability in disability, especially when the afflicted are not treated as objects of pity but are encouraged to discover their potential and reclaim their self-esteem. To this end, the Child Care Trust is structured to provide integrative support services in health care; educational, vocational and emotional support and training for physically and mentally challenged children. To assure the holistic development of the children, they are provided the full complement of boarding, feeding and recreational facilities at the home.

I know that there is a great deal of work yet to be done in the area of child care, especially the health and well-being of challenged children. Much of this work could be made easier and achievable if governments and children-friendly organizations collaborated more to develop and implement creative responses to the special needs of challenged children. The multisectoral approach, in my view, holds the best prospects of success, since a great number of these children are from very poor backgrounds in rural communities.

Once more, I thank the United Arab Emirates Health Foundation selection panel and the Executive Board of the World Health Organization for the award bestowed on me. I do very much appreciate this recognition and the opportunity it has afforded me to address this distinguished Health Assembly.

The PRESIDENT:

Thank you, Madam. We are proud of you; Africa is proud of you. WHO and the world are proud of you.

Presentation of the Sasakawa Health Prize
Remise du Prix Sasakawa pour la Santé

The PRESIDENT:

I now come to the presentation of the Sasakawa Health Prize. This Prize is awarded every year to individuals or institutions for outstanding innovative work in health development, and aims at encouraging the further development of such work.

It is my pleasure to announce that the 2004 Sasakawa Health Prize has been awarded to the Family Planning Association of Sri Lanka. The Family Planning Association of Sri Lanka has pioneered the implementation of a family planning programme in Sri Lanka through reproductive health education and counselling, especially for young people. The Association has also contributed to the improvement of health and family planning among internally displaced persons and to the increased use of contraceptives in the country. The Association promotes family planning among all levels of the population, carrying out activities such as the training of staff, volunteers, service providers, peer educators and counsellors. The Association proposes to use the prize money for a two-year family planning project in collaboration with the State, covering internally displaced persons and involving the local community.

I now invite Mr Yohei Sasakawa to address the Health Assembly on behalf of the Sasakawa Memorial Health Foundation.

Mr SASAKAWA (Sasakawa Memorial Health Foundation):

We are here today to honour the outstanding achievements of this year's recipient of the Sasakawa Health Prize: the Family Planning Association of Sri Lanka. For more than 50 years, the Association has conducted family planning promotion campaigns with great success. Since the 1990s, it has also become actively involved in a wide variety of other issues, ranging from adolescent reproductive health to gender and female employment.

The enjoyment of a healthy life is one of the most basic of human rights. This concept forms the basis of this award. In developing countries, however, issues such as a lack of finances, infrastructure or human resources sometimes make it difficult for people to achieve this. Sri Lanka has experienced over 30 years of ethnic conflict and farmers' revolts. Civil war has created more than a million refugees in the country. In spite of these difficult circumstances, the Family Planning Association has contributed to the improvement of health and family planning among internally displaced persons. It is my great pleasure to honour the Association for its outstanding achievement and present it with the Sasakawa Health Prize.

The question of the right to health is an important issue being dealt with not only by WHO, but also by the United Nations Commission on Human Rights. It is also something that I personally am working on as WHO's goodwill ambassador for leprosy elimination. In this capacity, and as President of The Nippon Foundation, I have been striving towards elimination for more than 30 years. Today, only about six endemic countries remain. Leprosy has become curable, thanks to the development of multidrug therapy. I am convinced that, by the end of 2005, we will have reached WHO's goal: elimination in every country of the world.

However, in no country has elimination brought a change in social attitude. Leprosy has been the most feared of diseases throughout human history. Its victims have been the ultimate outcasts of society, forced to lead lives that denied their very humanity. For this reason, last March I approached the United Nations Commission on Human Rights about this problem. There, I addressed the Member States on the issue of leprosy and human rights for the first time. Leprosy is a major problem that spans much of the globe. If we include the families and relatives of the affected, there are tens of millions of people suffering from discrimination. The right to health includes the right to enjoy a healthy life. But it also covers the right to be free from disease-related social discrimination. I am determined to continue my fight against the disease, as well as the discrimination that accompanies it.

In closing, I would again like to congratulate the Family Planning Association of Sri Lanka on being awarded the Sasakawa Health Prize. I have no doubt that this award will help the Association further enhance its activities and contribute more to the health and happiness of the people of Sri Lanka.

The PRESIDENT:

It is now my privilege to present the Sasakawa Health Prize to the President of the Family Planning Association of Sri Lanka, Mr Silva, who has done such wonderful work in Sri Lanka.

Amid applause, the President handed the Sasakawa Health Prize to Mr Silva.
Le Président remet le Prix Sasakawa pour la Santé à M. Silva. (Applaudissements)

Mr SILVA:

It is with both a sense of pride and humility that I accept the Sasakawa Health Prize on behalf of the Family Planning Association of Sri Lanka. It is a fitting tribute paid on our fiftieth anniversary; a tribute to 60 000 volunteers from all levels of society who, through the years, have worked with dedication, overcoming challenges from various quarters due mostly to ignorance, to create a society which by and large accepts family planning as a way of life.

On behalf of the Family Planning Association of Sri Lanka, let me thank WHO for selecting it to be the recipient of this prestigious Sasakawa Health Prize and organizing this magnificent function; the Sasakawa Memorial Health Foundation for initiating this award; the Ministry of Health of the

Government of Sri Lanka for nominating us; Dr Steven Sinding, Director-General of the International Planned Parenthood Federation and its former South Asia Regional Director, Dr Indira Kapoor; the volunteers and community-based organizations associated with our organisation; the former Executive Director Mr Daya Abeywickrema and all members of the staff of the Family Planning Association of Sri Lanka; and officials, especially from the Departments of Health, Education and Planning, for their invaluable support.

With the prize money we will be undertaking a two-year health promotional project in selected areas in the north-eastern province, targeting internally displaced persons who are now returning home to their villages. The project will aim to improve health and, in particular, reproductive health. Its focus will be on adolescents and youth who are the most vulnerable today. The proposed project will encourage community participation and foster closer involvement of community leaders in providing leadership at grass-roots level. We expect the project to empower and involve grass-roots volunteers to spearhead awareness creation and educational activities, while encouraging them to be the link connecting the community and service providers. The project will also foster a productive partnership between government and nongovernmental organizations working in the area of health so that the community can reap the maximum benefit from different programmes. The sustainability of the activities initiated by the project will be assured by this government and nongovernmental organization partnership, by community empowerment and the involvement of community leaders. Thank you WHO, thank you Sasakawa Health Foundation, for assisting us to improve the quality of life of our people.

The PRESIDENT:

Congratulations to the recipients of the awards. We hope and pray that you continue your good work for humanity and for the health of all people, especially the poor.

We have thus completed item 7 and this formal plenary session of the Health Assembly.

The meeting rose at 17:50.
La séance est levée à 17h50.

SEVENTH PLENARY MEETING

Friday, 21 May 2004, at 09:00

President: Mr Muhammad Nasir KHAN (Pakistan)

SEPTIEME SEANCE PLENIERE

Vendredi 21 mai 2004, 9 heures

Président: M. Muhammad Nasir KHAN (Pakistan)

1. SECOND REPORT OF THE COMMITTEE ON CREDENTIALS[1] DEUXIEME RAPPORT DE LA COMMISSION DE VERIFICATION DES POUVOIRS[1]

The PRESIDENT:

The Health Assembly is called to order.

The Health Assembly has to consider the second report of the Committee on Credentials. The report is contained in document A57/40 which you have all received. Delegates will note that it was the Bureau of the Committee on Credentials that examined the credentials of the Member States named in the report. Does the Health Assembly wish to comment on the report? In the absence of any comments, does the Health Assembly agree to approve this report? I see no objection. The report is therefore approved.

In addition, I have been informed by the Secretariat that, since the establishment of the report, formal credentials have been received from Nigeria, a Member State which has previously submitted provisional credentials, as is reflected in the Committee's first report. It has not been feasible to convene the Bureau of the Committee on Credentials to examine the formal credentials of Nigeria but, in accordance with previous practice, I have examined these credentials and have found them to be in keeping with the Rules of Procedure of the World Health Assembly. I would therefore recommend to the Health Assembly that Nigeria be accepted as having formal credentials.

Does the Health Assembly agree with this proposal? I see no objection. It is so decided.

[1] See reports of committees in document WHA57/2004/REC/3.

[1] Voir les rapports des commissions dans le document WHA57/2004/REC/3.

2. ANNOUNCEMENT
COMMUNICATION

The PRESIDENT:

When the General Committee met on Wednesday, 19 May 2004, it drew up the list for the annual election of Members entitled to designate a person to serve on the Executive Board and it reviewed the programme of work of the Health Assembly. When it met again on Thursday, 20 May 2004, it considered further the programme of work for the remainder of the Health Assembly, giving me the authority to consult with the Chairmen of the main committees to review the progress of their work and revise their programme, including the allocation of agenda items to each committee, if necessary.

After consideration of the progress of work in the main committees, the General Committee recommended that this plenary should meet this morning at 09:00 to consider item 6, "Executive Board: election" and item 8, "Reports of the main committees".

3. EXECUTIVE BOARD: ELECTION
CONSEIL EXECUTIF: ELECTION

The PRESIDENT:

We can now consider item 6, "Executive Board: election".

I draw your attention to the list of 12 Members, contained in document A57/38, drawn up by the General Committee in accordance with Rule 102 of the Rules of Procedure. In the General Committee's opinion these 12 Members would provide, if elected, a balanced distribution of the Board as a whole. These Members are, in the English alphabetical order: Australia, Bahrain, Bolivia, Brazil, Jamaica, Kenya, Lesotho, Libyan Arab Jamahiriya, Luxembourg, Romania, Thailand, and Tonga.

Is the Health Assembly prepared, in accordance with Rule 80 of the Rules of Procedure, to elect these 12 Members as proposed by the General Committee? I see no objection. I therefore declare the 12 Members elected. Congratulations. This election will be duly recorded in the records of the Health Assembly. May I take this opportunity to invite Members to pay due regard to the provisions of Article 24 of the Constitution when appointing a person to serve on the Executive Board.

4. REPORTS OF THE MAIN COMMITTEES[1]
RAPPORTS DES COMMISSIONS PRINCIPALES[1]

THE PRESIDENT:

We can now proceed to agenda item 8, "Reports of the main committees".

First report of Committee A
Premier rapport de la Commission A

Let us now consider the first report of Committee A. This is contained in document A57/39. Please disregard the word "Draft" as the Committee adopted the report without amendments. This report contains two resolutions and one decision.

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[1] See reports of committees in document WHA57/2004/REC/3.

[1] Voir les rapports des commissions dans le document WHA57/2004/REC/3.

The first resolution is entitled "Surveillance and control of *Mycobacterium ulcerans* disease (Buruli ulcer)". Is the Health Assembly willing to adopt this resolution? I see no objections. The resolution is adopted.

The second resolution is entitled "Control of human African trypanosomiasis". Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

Under agenda item 12.15, the Committee agreed on a decision entitled "Intellectual property rights, innovation and public health". Does the Health Assembly agree with this decision? I see no objections. It is so decided and the first report of Committee A is therefore approved.

First report of Committee B
Premier rapport de la Commission B

The PRESIDENT:

We shall now consider the first report of Committee B. It is contained in document A57/41. The report contains one resolution which is entitled "Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine". Is the Health Assembly willing to adopt this resolution? I see no objections. The resolution is adopted and the first report of Committee B is therefore approved.

I give the floor to the Libyan Arab Jamahiriya.

Mr AL HABIB (Libyan Arab Jamahiriya):

السيد الحبيب بن تامر (الجماهيرية العربية الليبية):

شكراً سيدي الرئيس،

نحن نطلب الكلمة لتبرير التصويت على مشروع القرار المعنون "الأحوال الصحية للسكان العرب في الأراضي المحتلة" بما فيها فلسطين ومساعدتهم. وفي هذا الإطار نود أن نوضح التالي:

١- إن ليبيا من الدول المتبنية لمشروع هذا القرار.

٢- نتيجة لظروف خارجة عن الإرادة، لسوء الحظ لم يكن عضو وفد ليبيا متواجداً في القاعة عند التصويت على مشروع القرار المشار إليه في اللجنة "ب".

٣- نود أن نؤكد أن ليبيا كانت ستصوت لصالح مشروع هذا القرار بنعم، ونود أن يدوّن ذلك في السجل الرسمي.

شكراً سيدي الرئيس.

The meeting rose at 09:30.
La séance est levée à 9h30.

EIGHTH PLENARY MEETING

Saturday, 22 May 2004, at 13:15

President: Mr Muhammad Nasir KHAN (Pakistan)

HUITIEME SEANCE PLENIERE

Samedi 22 mai 2004, 13h15

Président: M. Muhammad Nasir KHAN (Pakistan)

1. REPORTS OF THE MAIN COMMITTEES[1] (continued) RAPPORTS DES COMMISSIONS PRINCIPALES[1] (suite)

The PRESIDENT:

The Health Assembly is called to order. We shall continue agenda item 8, "Reports of the main committees".

Second report of Committee B
Deuxième rapport de la Commission B

We shall start with the consideration of the second report of Committee B contained in document A57/42. Please disregard the word "Draft" as the Committee adopted the report without amendments. The report contains one resolution which is entitled "Financial report on the accounts of WHO for 2002-2003; report of the External Auditor and comments thereon made on behalf of the Executive Board". Is the Health Assembly willing to adopt this resolution? I see no objection. The resolution is adopted and the second report of Committee B is therefore approved.

Third report of Committee B
Troisième rapport de la Commission B

We shall now consider the third report of Committee B contained in document A57/43. The report contains two resolutions. The first resolution is entitled "Members in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution". Is the Health Assembly willing to adopt this resolution? I see no objection. The resolution is now adopted.

[1] See reports of committees in document WHA57/2004/REC/3.

[1] Voir les rapports des commissions dans le document WHA57/2004/REC/3.

The second resolution is entitled "Arrears in payment of contributions: Ukraine". Is the Health Assembly willing to adopt this resolution? I see no objection. The resolution is adopted and the third report of Committee B is therefore approved.

Fourth report of Committee B
Quatrième rapport de la Commission B

I shall now proceed with the consideration of the fourth report of Committee B which is contained in document A57/45. Please disregard the word "Draft" as the Committee adopted this without amendments. The report contains three decisions and three resolutions.

Under agenda item 16.1 the Committee agreed on a decision entitled "Budget allocations to regions". Does the Health Assembly agree with this decision? I see no objection. It is so decided.

Under agenda item 17.3 the Committee agreed on a decision entitled "United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee". Does the Health Assembly agree with this decision? I see no objection. It is so decided.

The first resolution is entitled "Agreement with the *Office International des Epizooties*". Is the Health Assembly willing to adopt this resolution? I see no objection. The resolution is adopted.

The second resolution is entitled "Rules of Procedure of the World Health Assembly: amendment to Rule 72". Is the Health Assembly willing to adopt this resolution? I see no objection. The resolution is adopted.

Under agenda item 21 the Committee agreed on the decision entitled "Policy for relations with nongovernmental organizations". Does the Health Assembly agree with this decision? I see no objection. It is so decided.

The third resolution is entitled "Eradication of dracunculiasis". Is the Health Assembly willing to adopt this resolution? I see no objection. The resolution is adopted and the fourth report of Committee B is therefore approved.

Second report of Committee A
Deuxième rapport de la Commission A

We shall now consider the second report of Committee A which is contained in document A57/44 (Draft). The Committee adopted this report with an amendment to one resolution, which I will read to you as and when we consider the resolution. The report contains five resolutions. The first resolution is entitled "Road safety and health". Is the Health Assembly willing to adopt this resolution? I see no objection. The resolution is adopted.

The second resolution is entitled "Family and health in the context of the tenth anniversary of the International Year of the Family". Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is now adopted.

The third resolution is entitled "Reproductive health: draft strategy to accelerate progress towards the attainment of international development goals and targets". Is the Health Assembly ready to adopt this resolution? United States of America, you have the floor.

Mr MOLEY (United States of America):

While my delegation will not block consensus on the adoption of the resolution before us, the United States disassociates itself from endorsement of the strategy on reproductive health. We request that the records of the Fifty-seventh World Health Assembly clearly reflect this position.

The PRESIDENT:

The resolution is adopted and your comments are noted.

The fourth resolution is entitled "Genomics and world health". Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is adopted.

The fifth resolution is entitled "Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS". The Committee introduced a correction to the resolution you have before you, and I shall give the floor to the Secretariat to read out this correction.

Mr AITKEN (Director, Office of the Director-General):

The correction introduced was to operative paragraph 3, subparagraph 4, where the square brackets round that paragraph have to be removed.

The PRESIDENT:

Thank you. Is the Health Assembly willing to adopt this resolution as corrected? I see no objection. The resolution is adopted as corrected and the second report of Committee A is therefore approved, as corrected.

Fifth report of Committee B
Cinquième rapport de la Commission B

We shall now move on to consider the fifth report of Committee B which was presented orally to the Committee and was adopted. I shall propose that the Health Assembly follow the same procedure. Is this proposal acceptable? I see no objection. It is so decided.

The Committee approved one resolution entitled "Scale of assessments for 2005" which was contained in document A57/B/Conf.Paper No.4, without amendments. Is the Health Assembly willing to adopt this resolution? I see no objection. The resolution is adopted and the fifth report of Committee B is therefore approved.

Third report of Committee A
Troisième rapport de la Commission A

We shall now consider the third report of Committee A. Owing to time constraints, the report was presented orally to the Committee. We shall follow the same procedure as for the fifth report of Committee B. The Committee approved four resolutions.

The first resolution is entitled "Health promotion and healthy lifestyles" and was contained in document A57/A/Conf.Paper No.6. The Committee approved this resolution without amendment. Is the Health Assembly willing to adopt this resolution? I see no objection. The resolution is adopted.

The second resolution is entitled "Global strategy on diet, physical activity and health" and was contained in document A57/A/Conf.Paper No.5 Rev.1. The Committee approved this resolution with a correction. I shall ask the Secretariat to read out the proposed correction.

Mr AITKEN (Director, Office of the Director-General):

The correction is to eliminate a footnote in the Annex. The footnote appears on page 8 in the Spanish, English, French and Chinese texts, page 9 in the Arabic text, and page 10 in the Russian text.

The PRESIDENT:

Is the Health Assembly willing to adopt the resolution, as corrected? I see no objection. The resolution is adopted, as corrected.

The third resolution is entitled "Human organ and tissue transplantation" and was contained in document A57/A/Conf.Paper No.7. The Committee approved this resolution without amendment. Is the Health Assembly willing to adopt this resolution? I see no objection. The resolution is adopted.

The fourth resolution is entitled "International migration of health personnel: a challenge for health systems in developing countries" and was contained in document A57/A/Conf.Paper No.1 Rev.2. The Committee approved this resolution without amendment. Is the Health Assembly willing to

adopt this resolution? I see no objection. The resolution is adopted and the third report of Committee A is therefore approved.

This completes our consideration of item 8 of our agenda, "Reports of the main committees".

2. SELECTION OF THE COUNTRY OR REGION IN WHICH THE FIFTY-EIGHTH WORLD HEALTH ASSEMBLY WILL BE HELD
CHOIX DU PAYS OU DE LA REGION OU SE TIENDRA LA CINQUANTE-HUITIEME ASSEMBLEE MONDIALE DE LA SANTE

The PRESIDENT:

I should like to draw your attention to the fact that, under the provisions of Article 14 of the Constitution, the Health Assembly, at each annual session, shall select the country or region in which the next annual session shall be held, the Executive Board subsequently fixing the date and place.

I should also recall that the Thirty-eighth World Health Assembly concluded that it was in the interests of all Member States to maintain the practice of holding Health Assemblies at the site of the headquarters of the Organization.

I therefore take it that the Health Assembly decides that the Fifty-eighth World Health Assembly will be held in Switzerland. In the absence of any objections, it is so decided.

The meeting rose at 13:25.
La séance est levée à 13h25.

NINTH PLENARY MEETING

Saturday, 22 May 2004, at 14:00

President: Mr Muhammad Nasir KHAN (Pakistan)

NEUVIEME SEANCE PLENIERE

Samedi 22 mai 2004, 14 heures

Président: M. Muhammad Nasir KHAN (Pakistan)

CLOSURE OF THE SESSION
CLOTURE DE LA SESSION

The PRESIDENT:

The Health Assembly is called to order. We shall now consider the last item of our agenda - item 9, "Closure of the Assembly".

Before taking up the oral report on the work of the round tables, I should first like to thank Dr Phooko, Minister of Health of Lesotho, Dr Bethel, Minister of Health of Bahamas, Dr Keber, Minister of Health of Slovenia and Mr Olanguena Awono, Minster of Health of Cameroon for chairing the four round tables, as well as all the participants in this very interesting and stimulating experience. It is gratifying to note that the round tables, included for the first time in the Health Assembly's agenda five years ago, continue to be a valuable forum for the exchange of views and experience, enriching all of us.

I shall now ask Mr Olanguena Awono, Chairman of one of the round tables, to present an oral report summarizing the round-table discussions.

M. OLANGUENA AWONO (Cameroun) :

Monsieur le Président, Monsieur le Directeur général de l'OMS, Mesdames et Messieurs les Ministres, distingués délégués, c'est pour moi un grand honneur de vous présenter la synthèse des travaux des tables rondes organisées lors de cette Cinquante-Septième Assemblée mondiale de la Santé. Ces tables rondes ont été l'occasion pour nous ministres de la santé d'échanger des informations et de faire le point sur les problèmes que posent dans nos pays la prévention, les soins, le traitement de l'infection à VIH et le SIDA. Et surtout, les ministres ont discuté des stratégies novatrices en vue d'intensifier les interventions permettant de contrôler cette crise sanitaire mondiale.

La première table ronde s'est concentrée sur le rôle directeur que le secteur de la santé publique doit jouer pour améliorer l'accès au traitement des personnes infectées. Il apparaît que la très grande majorité des personnes infectées par le VIH vivant dans les pays en développement n'ont pas accès aux traitements antirétroviraux. Le groupe s'est donc félicité de l'initiative de l'OMS visant à permettre l'accès aux antirétroviraux à trois millions de personnes d'ici 2005. Pour atteindre cet objectif, le leadership politique des décideurs au niveau de nos pays et un plus grand engagement des

ministères de la santé sont perçus comme deux éléments clés. Une attention toute particulière doit aussi être accordée aux mesures permettant de réduire la discrimination envers les personnes infectées et de garantir un accès équitable aux services de santé à tous les patients, qu'ils soient hommes ou femmes. Les participants à la table ronde ont souhaité que l'OMS continue à exercer son rôle directeur pour soutenir les pays afin qu'ils renforcent leurs systèmes de santé pour assurer l'approvisionnement en antirétroviraux et pour coordonner l'intervention des partenaires.

La deuxième table ronde a discuté du renforcement de la capacité des services de santé à élargir l'accès au traitement du VIH dans les pays. Le groupe a noté que les services de santé doivent englober diagnostic, prévention et traitement. De plus, l'intégration avec des services comme la santé prénatale, la prise en charge des IST ou le traitement de la tuberculose doit être encouragée. L'amélioration des systèmes de santé doit tenir compte des besoins au niveau rural et s'accompagner d'un volet nutritionnel indispensable dans un contexte de pauvreté. Le rôle des guérisseurs, qui sont souvent consultés en premier par les patients, doit être davantage considéré et intégré dans la riposte globale des pays. Pour renforcer l'observance et la pérennité des traitements antirétroviraux, la participation des communautés et des groupes de patients vivant avec le VIH a aussi été perçue comme essentielle. Enfin, pour réduire le coût des antirétroviraux, les participants à la table ronde ont recommandé l'utilisation d'associations thérapeutiques à dose fixe et la production locale d'antirétroviraux. L'OMS devrait de son côté continuer à soutenir les pays pour qu'ils développent leurs systèmes d'agrément, d'approvisionnement et de contrôle de la qualité des médicaments.

La troisième table ronde s'est concentrée sur la mobilisation de partenaires et de ressources financières pour améliorer l'accès au traitement. Les ministres ont accueilli avec satisfaction le principe de travail « Trois fois un » et insisté sur son respect pour la cohérence des interventions. En effet, l'élargissement de l'accès aux antirétroviraux requiert un vaste partenariat, l'adoption d'un seul plan stratégique, l'existence d'une seule autorité nationale de coordination et d'un seul système de suivi/évaluation des programmes. La coordination et la cohérence des interventions sont des facteurs d'efficacité et devraient être renforcées. Cette approche devrait aussi permettre aux autorités nationales de jouer pleinement leur rôle normatif et conducteur et de faciliter, par ailleurs, l'adhésion des partenaires à la stratégie du pays. Dans ce sens, de nombreux pays ont fait part de leur expérience positive en matière de partenariat, en particulier avec le secteur privé, les organisations non gouvernementales et d'autres secteurs. Plusieurs délégués ont aussi noté l'insuffisance des ressources financières mises à leur disposition bien que la réduction du coût des antirétroviraux et l'augmentation des interventions du Fonds mondial de lutte contre le SIDA, la tuberculose et le paludisme commencent à combler le manque de financement. Malgré ces progrès, le problème de la soutenabilité et de la durabilité des interventions demeure préoccupant.

Le dernier groupe, que j'ai eu l'honneur de présider, a traité de l'intégration des programmes de prévention et de traitement dans les pays. Il est maintenant admis que les deux composantes prévention et traitement sont indissociables et se renforcent mutuellement. Une attention particulière doit être apportée au risque de relâchement des efforts de prévention maintenant que l'urgence des traitements est fortement soulignée. Les efforts de prévention doivent particulièrement cibler les groupes les plus vulnérables, à savoir les pauvres, les migrants, les utilisateurs de drogues intraveineuses et les travailleurs du sexe, tout comme les jeunes et les femmes. Enfin, les activités de diagnostic et de conseil doivent être intensifiées dans le cadre de l'intégration des services de prévention et de traitement, tout comme il a été recommandé d'intensifier la recherche sur les microbicides et un vaccin efficace.

(L'orateur poursuit en anglais.)
(The speaker continued in English.)

Permit me to sincerely thank Dr Lee, Director-General of WHO, for organizing these round tables on HIV/AIDS as part of the "3 by 5" initiative, which is aimed at scaling up access to antiretroviral drugs in developing countries. This is a very crucial moment in the history of our Organization, affecting the hope of millions of patients who are waiting for our decisions but, more importantly, our actions. Bridging the treatment gap between poor and rich must be seen as a giant step forward in reaching our common goals and promoting fundamental human rights. I thank all of

you for your valuable contribution and your important comments. I also thank the technical staff and Secretariat, the interpreters and all the other staff for their support.

Dear ministers, our duty in and with WHO must serve the needs of our common humanity. Let us join together and shape the future by continuously improving the well-being of mankind.

The PRESIDENT:

Thank you very much. The Health Assembly has now heard the summary report of the discussions at the round tables, and this will be included in the records of this Health Assembly.

I would now like to invite Dr Ponmek Dalaloy of the Lao People's Democratic Republic, Chairman of Committee A, to give the Assembly an overview of the work of Committee A.

Le Dr PONMEK DALALOY (République démocratique populaire lao) (Président de la Commission A) :

Monsieur le Président, Monsieur le Directeur général, Messieurs les Ministres, Mesdames et Messieurs, au nom de la Commission A, c'est pour notre équipe et pour moi-même un grand honneur d'avoir la responsabilité de faire rapport à l'Assemblée mondiale de la Santé sur le travail qui a été effectué ces jours-ci à la Commission A suivant l'ordre du jour qui nous a été imparti.

Au départ, les tâches sont à vrai dire difficiles car, d'un côté, les sujets à traiter sont à la fois nombreux et importants, certains très importants, et donc parfois controversés ou soulevant des points de vue variés et différents, quoique complémentaires, reflétant à la fois la richesse et la variété des situations dans les pays de toutes les régions du monde ou indiquant les objectifs, les buts, les mesures et les moyens requis ; d'un autre côté, le temps qui est déjà limité est encore plus compté à cause d'autres activités supplémentaires. En quatre jours et huit séances, nous avons examiné près de 16 points et sous-points et adopté un certain nombre de résolutions. Face à cette situation et à ces défis, notre équipe a mobilisé la sagacité, le savoir-faire, l'expérience, la sagesse, la détermination de tous afin de trouver la meilleure façon de procéder pour atteindre les objectifs visés, à savoir accomplir pleinement et à temps toutes les tâches qui nous étaient imparties.

Pour la première phase, soit pendant les deux premiers jours et demi, notre stratégie a consisté à donner à tous les Etats Membres et à toutes les organisations du système des Nations Unies et aux organisations non gouvernementales la possibilité de présenter à l'Assemblée de la Santé leurs pensées, leurs concepts, leurs points de vue, leurs commentaires, leurs observations et leurs recommandations, surtout concernant les problèmes centraux, tels que le VIH/SIDA, l'alimentation, l'exercice physique et la santé, la sécurité routière, la santé génésique, etc. Nous considérons qu'il est très important d'écouter les interventions des pays et des organisations, car elles sont la base sur laquelle se fonderont les groupes de rédaction qui ont la tâche de finaliser les projets de résolution.

Pour la deuxième phase, soit pendant une journée et demie, notre stratégie a consisté à conclure, synthétiser et élaborer un consensus à travers l'adoption de résolutions. En appliquant une telle stratégie et une telle méthode de travail, bien que les sujets soient nombreux et importants – donc suscitant un intérêt de très haut niveau et constructif –, variés et différents, quoique complémentaires, fondamentalement nous pouvons considérer que les objectifs fixés ont été atteints. De nombreux résultats ont été collectivement et laborieusement obtenus sous forme de résolutions, de stratégies, d'idées, ou encore de plans d'action, notamment concernant les problèmes les plus importants de notre temps, le temps de la mondialisation, à savoir : VIH/SIDA ; stratégie mondiale pour l'alimentation, l'exercice physique et la santé ; sécurité routière et santé ; famille et santé dans le contexte du dixième anniversaire de l'Année internationale de la famille ; santé génésique ; systèmes de santé, y compris soins de santé primaires ; qualité et innocuité des médicaments ; systèmes de réglementation ; transplantation d'organes et de tissus humains ; réduction de la mortalité par rougeole dans le monde ; SRAS ; prévention intégrée des maladies non transmissibles ; nutrition chez le nourrisson et le jeune enfant ; Convention-cadre de l'OMS pour la lutte antitabac ; ulcère de Buruli ; surveillance et lutte ; lutte contre la trypanosomiase humaine africaine ; droits de propriété intellectuelle, innovation et santé publique ; éradication de la variole : destruction des stocks de virus variolique ; éradication de la poliomyélite ; etc. Ce sont là de précieux acquis dont la portée et l'impact se feront sentir dans le futur

à travers tout le XXIe siècle, car ils reflètent à la fois les pathologies que nous avons à affronter, les progrès de la science et de la technologie en général, et les progrès de la biotechnologie en particulier, et surtout ils vont refléter nos modes de vie présents et futurs.

Si tout cela a été possible, c'est bien grâce à la haute et brillante direction du Président et du Bureau de l'Assemblée, à l'appui précieux et compétent du Secrétariat, au travail efficace, dévoué et décisif de tout le personnel technique et de soutien, et surtout à la participation extrêmement large, très active, multiforme et éminemment productive et positive des Etats Membres et des organisations. En cette dernière séance plénière de l'Assemblée mondiale de la Santé, au nom de notre équipe et en mon nom personnel, je voudrais exprimer nos sincères remerciements et notre profonde reconnaissance à tous pour nous avoir aidés à accomplir notre tâche. Merci.

The PRESIDENT:

I would like to congratulate you very warmly on your excellent presentation and also on the outstanding way in which you presided over the Committee.

I shall now invite the Chairman of Committee B, Dr Jigmi Singay of Bhutan, to report on the work of Committee B.

Dr JIGMI SINGAY (Bhutan) (Chairman of Committee B):

It is a great pleasure for me to present to you this report on the work of Committee B during this year's Health Assembly. I am only going to mention some of the highlights of the work of Committee B, since we have all had access to wonderful daily reports.

The work of Committee B concentrated, as usual, on programme and budget matters, financial matters, internal audit and oversight matters, staffing matters, legal matters and collaboration within the United Nations system, with other intergovernmental organizations and nongovernmental organizations. The Committee also took up discussions on the health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine. In addition, the Committee considered two subitems under "Technical and health matters", and two subitems under "Implementation of resolutions", which were transferred from Committee A. The discussions in Committee B were intense and constructive and they took place in a sensitive, collaborative spirit and in a framework of solidarity. Seven resolutions and three decisions were approved.

The Committee started its work with the discussion of the health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine. Twenty-six delegations took the floor. A roll-call vote was taken in accordance with Rule 74 of the Rules of Procedure. The draft resolution was approved, with 82 Members voting – 76 votes in favour, six votes against – and 39 abstentions.

Under the agenda item on internal audit and oversight matters, the report of the Internal Auditor was noted after being introduced by the Chairman of the Administration, Budget and Finance Committee of the Executive Board. Three subitems were dealt with under financial matters: namely, the financial report on the accounts of WHO for the year 2002-2003 including the report of the External Auditor and comments thereon made on behalf of the Executive Board, where the draft resolution was approved; the status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7, where two resolutions and one decision were approved; and lastly, the scale of assessments for the year 2005, which led to much debate and discussion, with the resolutions finally being approved by consensus today after further consultations.

Within the discussions on programme and budget matters, over 30 delegations expressed their views on the item on regular budget allocations to regions. A decision was approved by the Committee and the matter will be further discussed by the Executive Board at its 115th session.

Under staffing matters, the annual report on human resources was noted and a decision approved on the appointment of representatives to the WHO Staff Pension Committee.

Legal matters that the Committee dealt with were: (1) "Agreement with the *Office International des Epizooties*", discussions on which resulted in the approval of a resolution, and (2) "Rules of

Procedure of the World Health Assembly: amendment to Rule 72", which also saw the approval of a resolution.

An important aspect of the discussions on policy for relations with nongovernmental organizations was the impressive diversity of views. It was therefore decided that consideration of this new policy would be postponed until after the Director-General had consulted more broadly with all partners. A relevant resolution could then be submitted to a subsequent Health Assembly through the Executive Board.

Two subitems under technical and health matters were transferred from Committee A, namely: "Quality and safety of medicines: regulatory systems", which gave rise to much discussion and support of WHO's work in this area; and "Eradication of dracunculiasis", which resulted in the approval of the resolution and acknowledgement of the success of the programme.

Two subitems under the agenda item "Implementation of resolutions (progress reports)" were also transferred from Committee A, namely, "WHO Framework Convention on Tobacco Control" and "Integrated prevention of noncommunicable diseases". Discussions on both were enlightening.

It has been an honour and privilege for me, and for my country, to serve as Chairman of Committee B. We have been able to settle some important management and financial issues within a short space of time and in a constructive spirit. I would like to thank warmly all the delegations who contributed to settling our differences in a spirit of cooperation and solidarity. All this, of course, was only made possible because of the tremendous support and professional assistance we all received from the Secretariat of Committee B. I would like to salute the tremendous effort of all the professionals and support staff who have been at our disposal throughout this week to make sure that the Health Assembly could proceed smoothly and productively.

I thank you, Mr President, for your most able, dynamic and resourceful leadership, which has been instrumental in achieving the objective of this Health Assembly. I would also like to thank the Vice-Presidents for their commendable assistance and superb support in making this Health Assembly as successful as it has been. And to you, Director-General, I would like to extend our warm thanks – and here, I am sure, I speak on behalf of all of us – for your keen interest and your wonderful generosity in the strong support you have shown to our work at this, your first, Health Assembly. We wish you the very best for the coming years and already we are sure that you will accord us your unfailing support throughout.

Before we fly back to our respective homes, I should like to take this opportunity to wish all officers and delegates good health, peace and well-being during the coming year. Let me end by saying what they say here in this beautiful country, "Au revoir", and to those who are travelling, "Bon voyage".

The PRESIDENT:

I wish to thank you for your comprehensive report and for conducting the work of Committee B so well.

Now that the main committees have completed their work, including consideration of the Executive Board's reports, we are in a position to take note formally of these reports. From the comments which have been made, I take it that the Health Assembly wishes to commend the Board on the work performed and express its appreciation of the dedication with which the Board has carried out the task entrusted to it.

(Applause/Applaudissements)

The PRESIDENT:

In the absence of any comments, it is so decided.

The Director-General of WHO now has the floor.

The DIRECTOR-GENERAL:

The resolutions adopted by this Health Assembly have the potential to improve profoundly the health of millions of people. However, it is action taken following this Health Assembly that will turn that potential into reality: it is time to follow up.

Thank you Mr President, Vice-Presidents and the Committee Chairmen and Vice-Chairmen, for guiding the debates with such skill. We would also like to thank all of you who have contributed to the discussion. We assure you that we will work with you on the commitment made this week with urgency and energy.

The PRESIDENT:

Bismillah arrahman arrahim. At the outset, I extend my felicitations to the Health Assembly on the successful conclusion of its deliberations on an extremely heavy agenda. I pay tribute to fellow health ministers and distinguished delegates for active participation and consensual decision-making. I was also extremely impressed by the fact that most of my counterparts from WHO Member States came and stayed for the duration of the Assembly. I think it is critical for the ministers to be here in this august Health Assembly, and to give the political leadership. This helps make, in a short period of time, many decisions that will be implemented in our countries. I believe an august gathering like this creates harmony and communication between human beings. For example, a week ago I was just a telephone number to you, but in the week I have been here and talked to people and made new friends, today I am a human being and a human face to you. It is so important to have personal contact to remove any misunderstandings we might have had before that.

I would like to pay special tribute to Dr Lee for his vision and hands-on approach in leading WHO. During my close association with the Director-General this last week, I came to appreciate that he leads from the front, by example. I would like to assure him of my full support and cooperation during my presidency.

I must thank the Vice-Presidents, and the Chairmen, Vice-Chairmen and Rapporteurs of Committees A and B who put in long hours and patience to meet the demands of the agenda. The Health Assembly also owes a debt of gratitude to the invisible workers: the support staff of the Secretariat, translators, interpreters, and all those who contributed in their own special way to make this event a huge success. The Health Assembly also owes a debt of gratitude to all the people who have worked on the security staff.

I was greatly impressed by the quality of the debates during the course of the week. We heard a number of distinguished speakers and experts with vision and passion for improving the health of humanity. We heard Anastasia Kamylk of Belarus movingly describe the traumatic experience of living with HIV/AIDS, and make a passionate appeal to delegates to take decisions that will make antiretroviral therapy available to every victim of the disease, and end the social stigma attached to it.

The inspiring story of the struggle for peace of Dr Kim Dae-jung, the former President of the Republic of Korea and Nobel laureate, was a beacon of light for every peace-loving human being. We also had the privilege of hearing another icon of peace, Mr Jimmy Carter, former President of the United States of America. Mr Carter has worked for more than two decades forging friendships, forging partnerships, to bring peace, health and human rights to all people of the world irrespective of their colour, creed or religion. He symbolizes my firm conviction, which I have been expressing since my appointment as the Minister of Health of Pakistan, that "wherever there is peace, there is God".

I have listened to all the speakers of the distinguished delegations. Their pleas for affordable drugs, more assistance to the poor countries, better surveillance and data exchange and cooperation, and their concern and plea to end the conflicts and war are noted.

Following the unanimous adoption of the WHO Framework Convention on Tobacco Control by the Fifty-sixth World Health Assembly, many countries have signed the Framework Convention. As of today, the Framework Convention has been signed by 114 Member States of WHO and I congratulate every one of them. Moreover, the Convention has already been ratified by 15 Members. I myself had to wage a battle to pressurize my Government into signing the Framework Convention before the Fifty-seventh World Health Assembly. Lobbies of tobacco growers, the Central Board of

Revenue, and the tobacco industry are so strong and target third world countries with a great deal of finance and muscle. Further, the Ministry of Information and Media Development was strongly opposed to the signing of the Convention. But I am happy that my struggle bore fruit: I prevailed upon the Cabinet and the Prime Minister and the treaty was signed on 18 May 2004. Let me take this opportunity to remind Member States that in just five weeks – that is, on 29 June 2004 – the Framework Convention will close for signature. I therefore urge those Member States that have not already signed the Framework Convention to do so as soon as possible in order to demonstrate their political support for the treaty, and those Member States that have already signed, to proceed to ratify the Convention. WHO appreciates your efforts.

This Health Assembly has deliberated on two other important agenda points which merit special attention: genomics, and human organ and tissue transplantation. Genomic research has opened new vistas. There is now hope of diagnosis, prevention and management of those common inherited diseases caused by a single defective gene. However, there are potential risks and ethical issues associated with these technologies and I cannot overemphasize the ethical and moral issues which leaders of health have to follow strenuously. "Transplant tourism" is present in all WHO regions and the exploitation of the poorest and the most vulnerable parts of the population in low-income countries is rampant. I have heard of people selling kidneys for one transistor. There are people killing street children for organs. These things have to be taken into very serious consideration. I am so happy that the resolutions passed by the Health Assembly address these challenges and complexities.

Poliomyelitis eradication is in sight. I am confident that by the year 2005 when we meet here for the Fifty-eighth World Health Assembly, *inshallah*, the long battle against poliovirus will be won and we will have the happy news that poliomyelitis is a part of history and can be relegated to the medical textbooks. This is yet another example of WHO's transformation and enhancement from an action-oriented to a results-oriented organization. On this note I would like to thank personally the Director-General and the Regional Directors for their personal efforts.

It is my understanding that health systems need to be strengthened and based on the principle of primary health care, and health policies need to be evidence based to realize the goals of improving the health of the poor and the disadvantaged. As we succeed in preventing diseases, saving lives and controlling chronic conditions, we are surely contributing to population ageing. We have seen over the last 50 years an unprecedented increase in life expectancy at birth globally. By the year 2050 there will be 2000 million elderly people in the world, 85% of them in developing countries. This achievement brings with it a huge challenge to health systems to develop policies that ensure healthy ageing as well as security and protection for those who may need care at the end of their lives. Healthy older persons are resources for their families and economies. Ageing is a part of the development agenda and the commitment of our governments to support ageing individuals and societies is now, and has always been throughout history, the most refined measure of civilization. Today we are here, tomorrow we will be here as elderly persons – food for thought that we should consider.

I once again thank you all for your confidence and trust in electing me as the President of the Fifty-seventh World Health Assembly and for your very kind words and cooperation throughout this week. I am indebted to you and, with humility, thank you very much. I have tried to serve you all to the best of my ability and I hope you will forgive me for any mistakes.

I want to share a small story with you. A television company in Pakistan carried out a small survey. They were asking six-year-old children a question: "What do you think about war?". A six-year-old, beautiful, innocent Pakistani girl said – I will translate it – "Children should not fight, the elders should not fight: war is a terrible thing.". This could be the understatement of the year, maybe of our new millennium. When the new millennium came about, I was in the United Kingdom. There was so much jubilation that this new millennium would bring us happiness and so much passion for life, and that there would be so much improvement. Unfortunately, I think this six-year-old girl makes much more sense than we or the world leaders of today do. Maybe it is time that we learn from our children; maybe they make more sense than we do. Sometimes, they say, you need a brilliant mind to see the obvious. The obvious is in front of us: peace and harmony. Some say we should learn from history. It seems that humanity is condemned by history, but has not learnt from it. What we have seen over the last week on television is a sad reflection on humanity. It is a sad reflection on education. It is a sad reflection on all the universities of the world. We have Stanford, Harvard, Oxford, Cambridge

and thousands of universities throughout the world, yet man chooses the most ancient and the most barbaric tool to resolve disputes: war. Maybe it is time to close all the centres of education and go back to the jungle. It is an extremely sad reflection on all humanity.

We are all human beings and I believe that the most important gift to human beings is dignity. That is the critical thing, whether a person is poor or rich, or an aristocrat, or a king or a queen, or a president or a prime minister. Dignity is the key to human beings, wherever they are. So let us all, countries of Africa, Asia, North America, South America, Europe and Australia, work for dignity, peace, fairness and – most importantly – the health of mankind in this beautiful world of rivers, streams, mountains, birds, rain and flowers that we have inherited. Let the beautiful things like love, laughter, happiness and health cascade on to our beautiful earth. On this note, I wish all the distinguished delegates a safe journey back home and let us all, ministers and delegates of health, try to reach the ailing, unfortunate populations of our countries with compassion, understanding and leadership. Let us heal the world. Let us all, with the World Health Organization, and under the leadership of the Director-General, try to heal mankind. May God help and guide us. *Assalamu alaikum*.

(*Applause/Applaudissments*)

I formally declare the Fifty-seventh World Health Assembly closed.

The meeting rose at 14:15.
La séance est levée à 14h15.

COMPOSITION DE L'ASSEMBLEE DE LA SANTE
MEMBERSHIP OF THE HEALTH ASSEMBLY

LISTE DES DELEGUES ET AUTRES PARTICIPANTS
LIST OF DELEGATES AND OTHER PARTICIPANTS

DELEGATIONS DES ETATS MEMBRES
DELEGATIONS OF MEMBER STATES

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(Chief delegate from 17 to 18 May 2004)

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